Policy and Procedures for Staff Review Panels

1. The meetings of the Board, its six committees (Finance, Delivery System, Benefits, Enrollment & Eligibility, Health Equities and Federal Law) and the formal work groups created by the committees (currently Insurance Exchange [Finance Committee] and Quality Institute [Delivery System]) are subject to public meetings requirements. This has been and will continue to be the operating policy of OHFB/OHPR.

2. Staff can meet with interested individuals for discussions that are not subject to the public meetings law.

3. OHFB/OHPR staff may invite members of the Board, committees and work groups and other "content experts" to meet with staff to provide consultation (comments, suggestions, input or document reviews) about specific issues on which staff is working. Such consultations will be called "ad hoc" staff review panels.

The following procedures should be followed:

A. The ad hoc staff review panel is initiated by the lead staff person.

B. If participants of the ad hoc staff review panel include members of the Board, committees or work groups, those participants will not represent a quorum of the Board, committee or work group.

C. The purpose of the ad hoc staff review panel is to provide consultation to the OFHB/OHPR staff.

D. An ad hoc staff review panel should be short-lived; i.e., one or two meetings.

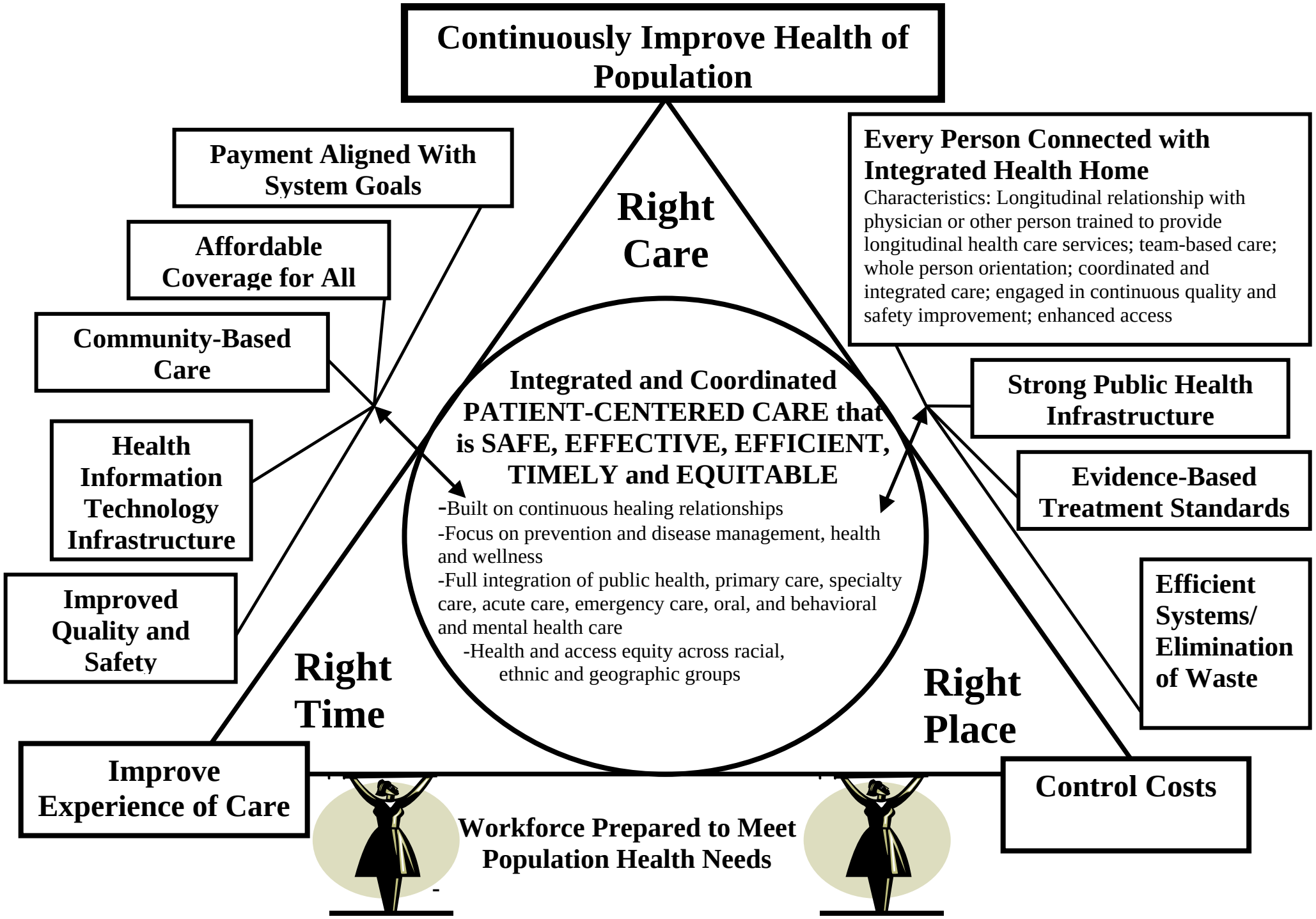
E. The lead staff person may consider the comments, suggestions and consultation provided by the participants in the ad hoc staff review panel, and in the exercise of the lead staff person's discretion, may use, revise or decline to use the suggestions provided to staff by the participants.

4. The following staff is authorized to convene ad hoc staff review panels:

Barney Speight (All issues)
Jeanene Smith, MD (All issues)
Tina Edlund (All issues)
Gretchen Morley (Finance)
Nora Leibowitz (Finance)
Darren Coffman (Benefits)
Heidi Allen (Health Equities)
Susan Otter (Federal Laws)

5. For documentation, an email should be sent to the invited participants of the staff review panel briefly highlighting 2 A - E, above. Please copy Barney, Jeanene and Tina.

Framework for Delivery System Reform in Oregon
DRAFT 1/10/08



Excepts from Reports Consulted in Developing Framework for Delivery System Reform

Institute of Medicine (IOM)– Crossing the Quality Chasm
http://books.nap.edu/openbook.php?record_id=10027&page=R1

The committee proposes six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should. Health care should be:

- Safe - avoiding injuries to patients from the care that is intended to help them.
- Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centered - providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely - reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient - avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Institute for Healthcare Improvement (IHI) – Best Health Care Results for the Population: The Triple Aim
http://www.ihi.org/NR/rdonlyres/5FFFC58F-3236-4FB7-8C38-2F07CC332AE3/0/IHITripleAimTechnicalBriefJune2007.pdf

Transformation of health care delivery starts with a transformational aim. The Institute for Healthcare Improvement believes that one such transformational aim includes a balance or optimization of performance on three dimensions of care—which IHI calls the "Triple Aim":

1. The health of a defined population;
2. The experience of care by the people in this population; and
3. The cost per capita of providing care for this population.

These three dimensions of care pull on the health care system from different directions. Changing any one of the three has consequences for the other two, either in the same or opposite directions. For example, improving health can raise costs; reducing costs can create poor outcomes, poor experience of care, or both; and patients' experience of care can improve without improving health. With the goal of optimizing performance on all three dimensions of care, we recognize the dynamics of each dimension while seeking the intersection of best performance on all three.

2006 Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs – Four Cornerstones
http://www.hhs.gov/valuedriven/fourcornerstones/index.html

The Executive Order is intended to ensure that health care programs administered or sponsored by the federal government build on collaborative efforts to promote four cornerstones for health care improvement:

1. **Interoperable Health Information Technology (Health IT Standards):** Interoperable health information technology has the potential to create greater efficiency in health care delivery. Significant progress has been made to develop standards that enable health information systems to communicate and exchange data quickly and securely to protect patient privacy. Additional standards must be developed and all health care systems and products should meet these standards as they are acquired or upgraded.
2. **Measure and Publish Quality Information (Quality Standards):** To make confident decisions about their health care providers and treatment options, consumers need quality of care information. Similarly, this information is important to providers who are interested in improving the quality of care they deliver. Quality measurement should be based on measures that are developed through consensus-based processes involving all stakeholders, such as the processes used by the AQA (multi-stakeholder group focused on physician quality measurement) and the Hospital Quality Alliance.
3. **Measure and Publish Price Information (Price Standards):** To make confident decisions about their health care providers and treatment options, consumers also need price information. Efforts are underway to develop uniform approaches to measuring and reporting price information for the benefit of consumers. In addition, strategies are being developed to measure the overall cost of services for common episodes of care and the treatment of common chronic diseases.
4. **Promote Quality and Efficiency of Care (Incentives):** All parties - providers, patients, insurance plans, and payers - should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively-priced health care. Such arrangements may include implementation of pay-for-performance methods of reimbursement for providers or the offering of consumer-directed health plan products, such as account-based plans for enrollees in employer-sponsored health benefit plans.

Delivery System Committee
Strawperson Policy Recommendations
Promotion of Integrated Health Homes
DRAFT FOR DISCUSSION ONLY 1/17/08

Recommendation 1: Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Program and eventually widespread statewide adoption so available to all Oregonians. A standard definition of integrated health home should be developed for Oregon that allows for innovation and encompasses a range of models.

Option to consider: (may be alternative options)
Endorse (with modifications) the definition of a "patient-centered medical home" developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA). Key aspects to include are:

- *Personal connection with practice* **–** Every patient has available an established and continuous relationship with a provider or provider group working in a practice that meets all criteria of an integrated health home. This could be with a primary care physician, nurse practitioner or others trained to provide longitudinal health care services. These services can be provided within the care setting or through coordinated virtual networks.
- *Team-based Care* - A coherent team of providers are collectively responsible for the patient's longitudinal health needs. Roles within the team are assigned to maximize the efficient use of resources and responsiveness to patient needs. Teams are built around and include the patient and patient's family (when appropriate).
- *Whole Person Orientation* **–** Integrated health homes assumes responsibility for providing culturally competent care for all of the patient's health care needs, including acute care, preventative, disease management services, and end of life care. The medical home provides direct care when possible and arranges for appropriate referrals to other providers and other health and social services.
- *Coordinated and Integrated Care* - Care received from the integrated health home is coordinated/integrated with care received from other providers and organizations, as well as with services provided within a patient's community, including public health, oral health, mental health, and behavioral health services. Coordination allows patients to receive appropriate care when and where they need it. Registries, information technology, information exchange, and other resources are utilized by the integrated health home to establish and facilitate coordination.
- *Quality and Safety* **–** Integrated health homes focus on quality improvement and safety, through physician participation in performance measurement and improvement efforts, use of clinical decision-support technology, and clinical

- standards and guidelines built on evidence-based medicine. Patients participate in shared decision-making, quality improvement efforts and practice evaluation.
- *Enhanced Access* – Patient access to both office-based and non-office based care is expanded through mechanisms such as longer hours, group visits, open scheduling, phone and email visits, and other web-based communication.

Recommendation 2: Develop common processes for designating practices across the state as integrated health homes and develop (endorse) a set of common measures of integrated health home process and performance.

- The designation processes should be tiered to acknowledge various levels of progress toward evolution into fully integrated health homes.

  Option to consider*:* Build statewide recognition program based on National Committee for Quality Assurance (NCQA) Physician Practice Connection Patient-Centered Medical Home program and/or PEBB Vision criteria of a medical home.

- The common set of measures should build on national standards and current efforts to measure quality, cost, and efficiency in Oregon. Measures should include process and outcomes measures, be designed to measure longitudinal clinical outcomes for individuals as well as provider panels, and include measures of population health. A process should be developed to ensure that measurement and designation process is fluid and regularly updated. Such measurement could be via the Quality Institute, which could also be responsible for collecting baseline data. *Await Quality Institute WG recommendations*

Recommendation 3: Create integrated networks (real and virtual) which connect integrated health homes with community, public health, behavioral health, oral health, and social services to improve population health.
Staff will discuss possible strategies with other state agencies and develop options for Committee to consider.

Recommendation 4: Provide Oregon's primary care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes.
State strategies for responding to primary care workforce shortage will be addressed in future recommendations

Options to consider:
- Forum for those participating/funding demonstration projects to come together to share best practices and discuss challenges
- Learning collaboratives that give providers and other stakeholders the opportunity to share and develop best practices and partner with public health to facilitate the use of data to improve individual and population health

- Funds for demonstration projects, especially in rural and underserved areas. May consider funding demonstration projects where specialist (e.g. endocrinologist for patient with diabetes or mental health professional for patient with mental illness or dentist) serves as integrated health home
- Grants to practices to build HIT infrastructure, disease registries, hire case management staff, etc.
- System improvement training and other technical assistance

Recommendation 5: Develop reimbursement strategies that promote and sustain integrated health homes.

1) *Initial pilots to encourage change and develop initial assessments of outcomes*

Option to consider: Initial pilot projects that build on and coordinate current statewide integrated health home pilots. This could include one-time grants to providers to build infrastructure necessary to carry out integrated health home functions, including building HIT infrastructure, hiring case management staff, etc.

2) Consider implementing strategies directed towards individual program participants. Implementation of such strategies should be tied to an evaluation to determine whether such strategies improve individual health outcomes and population health.

Option to consider: Rewards/incentives for program participants who enroll with integrated health home and/or seek out preventative services, effectively manage chronic disease with support from health homes, practice healthy behaviors, etc.

3) *Develop long-term sustainable payment policies that appropriately compensate providers for developing capacity to provide integrated health home services and providing these services to Oregonians in a way that promotes quality and value.*

A mixed model of reimbursement will probably have to be developed, which includes fee for service payments for certain procedures and risk-adjusted bundled payments for providing integrated health home services. Payment should be tied to reporting requirements of common measures (see Recommendation 2) and an auditing process will have to be developed.

***Committee will use February meeting to discuss specific reimbursement models targeted at promoting integrated health homes, as well as options that can be applied to primary care and across the wider delivery system.

CREATING PAYMENT SYSTEMS TO ACCELERATE VALUE-DRIVEN HEALTH CARE
Issues and Options for Policy Reform

by

Harold D. Miller, Pittsburgh Regional Health Initiative

Support for the preparation of this paper was provided by The Commonwealth Fund, the California HealthCare Foundation, and the Jewish Healthcare Foundation. The views presented here are those of the author and should not be attributed to The Commonwealth Fund, the California HealthCare Foundation, the Jewish Healthcare Foundation, or their directors, officers, or staff.

CONTENTS

About the Author

Harold D. Miller is the Strategic Initiatives Consultant for the Pittsburgh Regional Health Initiative and the Jewish Healthcare Foundation in Pittsburgh. He is also President of Future Strategies, LLC, a management and policy consulting firm in Pittsburgh, Pennsylvania, and he serves as Adjunct Professor of Public Policy and Management at Carnegie Mellon University's Heinz School of Public Policy and Management.

Miller previously served as the President of the Allegheny Conference on Community Development, the Executive Director of the Pennsylvania Economy League of Southwestern Pennsylvania, the Associate Dean of the H. John Heinz III School of Public Policy and Management at Carnegie Mellon University, and Director of the Governor's Office of Policy Development in Pennsylvania during the Thornburgh Administration.

Miller received his Master of Science in Public Management and Policy from the Heinz School at Carnegie Mellon University.

Acknowledgements

This paper was originally prepared for the Network for Regional Healthcare Improvement, which convened a national Summit on March 29, 2007 in order to accelerate thinking about how healthcare payment systems can be redesigned to reward quality as well as reduce costs. The paper is based on the ideas and research of many practitioners and researchers. The author is grateful for the extremely valuable comments and input on earlier drafts of this paper provided by Sophia Chang, Karen Wolk Feinstein, Michael Forlenza, Anne Gauthier, Peter Lee, Tania Lyon, Sanne Magnan, Barbra Rabson, Stephen Schoenbaum, Anthony Shih, Stanley Wallack, and Nancy Zionts, but any errors or omissions in the current version are entirely the responsibility of the author. Financial support for the preparation of this paper was provided by The Commonwealth Fund, the California HealthCare Foundation, and the Jewish Healthcare Foundation.

Abstract

This paper is designed to assist healthcare payers and policymakers to restructure payment systems in ways that will improve the quality of health care and reduce (or slow the growth in) the costs of health care. Drawing on the research and proposals of many researchers and practitioners, it attempts to:

- summarize the key concepts involved in any discussion of ways to restructure payment systems;
- catalog the quality and cost problems that current payment systems create;
- list the key concerns that have been raised about pay-for-performance systems in health care;
- propose twelve goals that revised payment systems should seek to achieve in order to effectively address the problems;
- define the specific issues that need to be resolved in order to achieve these goals;
- describe the primary options for addressing each of these issues; and
- suggest a general strategy for making progress on payment restructuring.

Executive Summary

The Need for Improved Payment Systems

A growing number of healthcare professionals around the country are increasingly frustrated by healthcare payment systems that do not reward efforts to improve healthcare quality, and that often financially penalize them. There is fairly widespread agreement that one reason for high costs and quality gaps is that current healthcare payment systems provide significant financial penalties and disincentives to providers (hospitals, physicians, and others) who provide quality, efficient care (e.g., lower-cost services, higher-quality care, cognitive services, preventive care, etc.) and significant incentives for providing expensive, inefficient care (e.g., invasive treatment, use of technology, etc.) irrespective of outcomes.

Current payment systems create penalties and disincentives across all elements of health care, including the prevention of illness, diagnosis, treatment of conditions, and the follow-up to care. For example:

- Current fee for service systems generally do not pay adequately (or at all) for many elements of preventive care. In addition, low payment levels are believed to be discouraging physicians from entering primary care vs. specialty care.
- Payers often do not have an incentive to invest in preventive care, since the payoff in terms of better health and lower costs occurs in the (distant) future and may accrue to other payers.
- Fee-for-service systems may not pay adequately for the time needed by a provider to make an accurate diagnosis and to develop an appropriate care plan and discuss it with their patient, particularly in complex or unusual cases. At the same time, providers are not financially penalized for ordering more tests, regardless of whether they are necessary to make an accurate diagnosis/prognosis.
- Fee for service payment systems reward providers for providing more services, even if they are unnecessary or of low value. Moreover, payment systems generally pay for services regardless of whether all of the processes recommended in clinical practice guidelines are performed by the provider, and research has shown that large proportions of patients do not receive important elements of care.
- Under most payment systems, providers are paid more for patients experiencing adverse events, particularly serious adverse events resulting in multiple complications, and the provider's "profits" on patients experiencing such events may actually be higher than on patients with no adverse events.
- Payment systems reinforce fragmentation of care by paying multiple providers for multiple services or tests for the same patient, regardless of whether the care is coordinated or duplicative.
- Current payment systems generally do not pay hospitals or physicians more to manage the needs of patients with complex conditions after discharge from the hospital or to proactively work to encourage and assist the patient in complying

with post-discharge instructions in order to improve outcomes and prevent re-hospitalization.

- Patients generally do not have a financial incentive to adhere to prevention and disease management recommendations that could improve outcomes and reduce health care costs. Copayments and deductibles may discourage or prevent individuals from obtaining desirable preventive care services.
- Many payers do not have mechanisms for encouraging or directing patients to providers which provide better value, i.e., care at lower cost for the same quality, or higher quality at the same cost.

The Weaknesses of Current Pay-for-Performance Systems

Although a wide range of pay-for-performance, or P4P, systems have been developed to try and counteract some of these kinds of problems, there is growing concern that these systems are inadequate and potentially counterproductive. For example:

- The amount of performance bonuses and penalties in most P4P systems is relatively small, reducing the likelihood that they will overcome the problems they are intended to address. In fact, the reductions in a provider's net revenues from implementing a quality improvement initiative may exceed the payment incentives provided through a pay for performance system for that initiative.
- Most P4P systems focus on rewarding processes, rather than outcomes, which may (a) reward providers with poorer outcomes, and (b) unintentionally deter innovation and experimentation with new processes that achieve better outcomes.
- Measures are only available for a subset of the processes that are important to good outcomes; pay for performance systems that reward a subset of processes may divert attention from other important processes.
- Providing incentives based on outcomes (or even some processes) can create incentives for providers to exclude or undertreat patients who are likely to have poor outcomes or to be non-compliant with treatment regimes, or to overtreat patients who are likely to have better outcomes or be more compliant.
- Because of the fragmentation of care, it is often difficult or impossible to clearly assign responsibility for performance or lack of performance to a particular provider.

Potential Goals for Effective Value-Based Healthcare Payment Systems

In order to address the problems with current payment systems and avoid the concerns about existing pay for performance systems, the following are twelve potential goals that revised payment systems could seek to achieve:

1. Payment systems should enable and encourage providers to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner.
2. Payment systems should support and encourage investments, innovations, and other actions by providers that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs.
3. Payment systems should not encourage or reward overtreatment, use of unnecessarily expensive services, unnecessary hospitalization or re-hospitalization, provision of services with poor patient outcomes, inefficient service delivery, or encouraging choices about preference-sensitive services that are not compatible with patient desires.
4. Payment systems should not reward providers for undertreatment of patients or for the exclusion of patients with serious conditions or multiple risk factors.
5. Payment systems should not reward provider errors or adverse events.
6. Payment systems should make providers responsible for quality and costs within their control, but not for quality or costs outside of their control.
7. Payment systems should support and encourage coordination of care among multiple providers, and should discourage providers from shifting costs to other providers without explicit agreements to do so.
8. Payment systems should encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce the costs of care.
9. Payment systems should not reward short-term cost reductions at the expense of long-term cost reductions, and should not increase indirect costs in order to reduce direct costs.
10. Payment systems should not encourage providers to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers.
11. Payment systems should minimize the administrative costs for providers in complying with payment system requirements.
12. Different payers should align their standards and methods of payment in order to avoid unnecessary differences in incentives for providers.

Issues and Options for Improved Healthcare Payment Systems

Five categories of issues need to be addressed in redesigning healthcare payment systems to meet these goals:

1. The basic method of payment to be used to compensate providers for this type of care, i.e., fee for service, episode-of-care, capitation, or some other approach;
2. Whether payments for multiple providers should be “bundled” together;
3. How the actual level of payment should be determined;

4. What performance standards should be set and whether incentives for performance should be added to the basic payment method; and
5. Whether specific incentives should be provided to patients regarding choice of providers and participation in care.

There are multiple options available to address each of these issues, many of which are described in Section VI of the paper. In addition, different types of payment may be appropriate for different types of patients and conditions. Examples are provided in Section VI of how the options can be combined into revised payment systems for several types of patients/conditions.

If incentives for performance are to be used, then nine additional issues need to be addressed:

1. How should payments be changed based on provider compliance with non-mandatory processes?
2. How should payments be changed based on provider achievement of better patient outcomes?
3. How should payments be changed based on reduced utilization of services (or otherwise lower costs or slower growth in costs)?
4. How should payments be changed based on achievement of higher patient satisfaction levels?
5. Should payments be changed based on any other situations?
6. What threshold of performance should trigger payment changes?
7. How large should rewards or penalties be relative to base payment levels?
8. How should high-cost patients be protected against exclusion from care?
9. Should there be any adjustment in payment levels to reflect costs of information technology that providers need to comply with requirements for reporting on processes, outcomes, patient satisfaction, or reduced utilization/cost?

Again, there are multiple options available for addressing these issues, many of which are described in Section VII of the paper.

In addition, both basic payment systems and incentive systems presume the existence of:

- Categories of diagnosis and patient severity (and age and risk) for which payment levels can be consistently established;
- Guidelines for care (often called Clinical Practice Guidelines) for each category of diagnosis and patient severity;
- Estimates of the cost to providers of following guidelines for care in an efficient manner;
- Performance measures for each category of diagnosis and patient severity; and

- Methods of collecting and reporting on performance measures.

In many regions of the country, systems are in place for one or more of these activities, but in others, they are not. In addition, concerns have been raised about whether the processes that are in place at the national level are moving quickly enough. Options for addressing these issues are described in Section VIII of the paper.

Finally, several important issues need to be resolved in implementing a desired payment system, including:

- How should payment changes be phased in?
- Should payment changes be required to be "budget neutral?"
- How will the effects of payment changes be evaluated?

Some options for addressing these issues are described in Section IX of the paper.

Next Steps in Improving Payment Systems

Unfortunately, there are no easy answers regarding which options offer the best resolution for these many issues. Uncertainty exists due to the fact that there have been relatively few cases where significantly different payment systems have been attempted, and even fewer where thorough evaluations have been conducted. This leads to several conclusions about next steps:

- Payment demonstration projects must be developed, implemented, and evaluated in order to make progress on payment reform.
- A wide variety of payment demonstrations are needed. Just as experimentation and evaluation is a hallmark of evidence-based medicine, experimentation and evaluation will also likely be needed in order to develop the most effective cure for the ills of the payment system.
- The leadership for payment reform demonstrations should come from the regional level, rather than the national level. Health care is a fundamentally regional enterprise, since most providers and even most payers operate exclusively or primarily in metropolitan regions, states, or multi-state areas.
- While payment demonstrations can and should be pursued at the regional level, this does not mean that payment reform should be a parochial enterprise. Indeed, just as medicine itself advances the state-of-the-art through local innovations that are supported, replicated, and evaluated nationally, so too can payment reform be more successful if there is national support for the development, evaluation, and replication of regional payment demonstrations.

I. Introduction

A growing number of healthcare professionals around the country are increasingly frustrated by healthcare payment systems that do not reward efforts to improve healthcare quality, and that often financially penalize them. There is fairly widespread agreement that:

PREMISE 1.1: Healthcare systems are not providing the highest quality care possible for the money currently being spent.

PREMISE 1.2: The same or higher quality health care could be provided for less money than is being spent today.

PREMISE 2: One reason for high costs and quality gaps is that current healthcare payment systems provide significant financial penalties and disincentives to providers (hospitals, physicians, and others) who provide quality, efficient care (e.g., lower-cost services, higher-quality care, cognitive services, preventive care, etc.) and significant incentives for providing expensive, inefficient care (e.g., invasive treatment, use of technology, etc.) irrespective of outcomes.

PREMISE 3: Factors other than the financial penalties and disincentives in the payment system also cause increased costs and reduced quality of health care (e.g., lack of training for healthcare professionals in methods of identifying and reducing waste; defensive medicine driven by liability concerns).

PREMISE 4: Changing the structure of payment systems appropriately has the potential to increase the quality and/or reduce (or at least control the growth in) the costs of health care.

In order to address the problems described in Premises 1.1, 1.2, and 2, and to realize the opportunity inherent in Premise 4, there are two basic paths which could be followed:

PATH #1: Eliminate or modify the aspects of current healthcare payment systems which provide penalties or disincentives for lower-cost, higher-quality health care.

PATH #2: Add new rewards or incentives to existing healthcare payment systems to encourage lower-cost, higher-quality health care.

Most current pay-for-performance (P4P) programs and demonstrations are following primarily Path #2, leaving the current payment system structure alone, and adding a new layer of rewards and incentives on top of it.

However, there appears to be a growing consensus among healthcare purchasers, plans, providers, researchers, and policy-makers that Path #2 alone is inadequate, and that:

PREMISE 5: In order to achieve the most efficient, effective, and sustainable improvements in quality and reductions (or slowing the growth) in costs, the penalties and disincentives in current healthcare payment systems need to be eliminated or modified (i.e., Path #1), in addition to adding rewards or incentives (Path #2).

Consistent with this premise, this paper attempts to outline information needed to address two key questions:

QUESTION 1: What fundamental changes should be made in the structure of current healthcare payment systems in order to eliminate (or significantly reduce) the current penalties and disincentives for higher-quality, lower-cost health care?

QUESTION 2: What incremental rewards or penalties, if any, should be added to restructured healthcare payment systems in order to specifically encourage higher quality, lower-cost healthcare and discourage lower quality, higher-cost healthcare?

It is important to recognize the implications of Premise #4 – not all quality and cost problems are caused by payment systems, and not all quality and cost problems can be resolved by changes in payment systems, i.e., payment reform is not a panacea for the problems in health care. In designing and evaluating changes to payment systems, it will be important to clearly define what kinds of changes in quality and cost are expected to result and also to clearly define the logical connection between the payment system changes and the expected changes in quality and/or cost.

II. Key Concepts for Restructuring Payment Systems

Discussions about payment systems in health care inherently encompass several key concepts – the different types of methods by which payment can be made to healthcare providers; the different types of patients and conditions for which payment is being made; the different types of costs involved; and the different types of performance that payment systems might be expected to encourage (or not discourage). In order to help organize discussions regarding ways to restructure payment systems, definitions and potential taxonomies for each of these concepts are offered below.

A. Definitions of Terms

For simplicity, the term "payer" is used throughout this paper to refer to organizations or individuals purchasing health care directly from health care providers, whether they be health insurance plans, self-insured organizations (directly or through third-party administrators), government agencies paying for health care (such as Medicare and state Medicaid agencies), or self-pay individuals. The cost or payment by the ultimate purchaser (e.g., an employer) may be very different from the cost or payment by a health plan that they use as the direct payer, but this is a function of the structure of the insurance contract between the purchaser and the payer, and will not be addressed in this paper. This paper will focus on payments made directly to providers for care of patients and on the costs incurred by patients and their employers for both the provision of health care and the results of health care (see Section II-E). However, it is important to note that the benefit and cost structure of health plans has a significant effect on both the payment structure for providers and the incentives for patients.

The term "provider" is used to refer to organizations and individuals providing health care to individuals, including hospitals, physicians, clinics, nursing homes, diagnostic labs, etc. This may include patients themselves, through self-care regimes.

The term "patient" is used to refer to individuals receiving health care services, including healthy individuals receiving preventive care.

The term "care" refers to services and processes involving patients that are designed to improve their health or prevent it from worsening. This includes services provided by patients themselves, by physicians, diagnostic services provided by laboratories, drugs and medical devices (whether self-administered or administered by health professionals), and non-physician services and facility-based care, such as hospitals, home health agencies, rehabilitation facilities, nursing homes, etc. (See Section II-D.)

An "episode of care" means a set of services whose beginning and end is defined by the beginning and end of the patient's condition or course of treatment, rather than the beginning or end of a particular provider's service or services. Theoretically, a full episode of care runs from the initial diagnosis of a condition to completion of all treatment of that condition. However, because some patients will never be "cured" of a condition, such as patients with a chronic disease, and because patients who do not have a

preventable disease may take prevention steps for a long period of time, for practical purposes an episode of care for preventive health or chronic disease may be defined in a more time-limited fashion. Similarly, because of fragmented delivery structures, some episode-of-care payment systems focus on a portion of the complete episode of care that is delivered by a particular provider or group of providers (see Sections II-B and II-D).

A "payment system" is the methodology that a payer uses to compensate one or more providers for the care provided to a patient. This includes definitions of what will be compensated and what will not be compensated, the general way that compensation will vary depending on characteristics of the patient or the care provided, which providers and/or costs will be covered under a single payment, etc.

The term "value" will be used to refer to the ratio of the quality of health care to the cost of care, i.e., more quality for the same cost is higher value, and the same quality for lower cost is also higher value.

The term "value-based payment system" means that in some fashion, payment is based on the value of care provided.

B. Types of Payment Methods

Although there are many different ways to pay for health care, one can define six different conceptual types of payment methods along a continuum (see Figure 1).

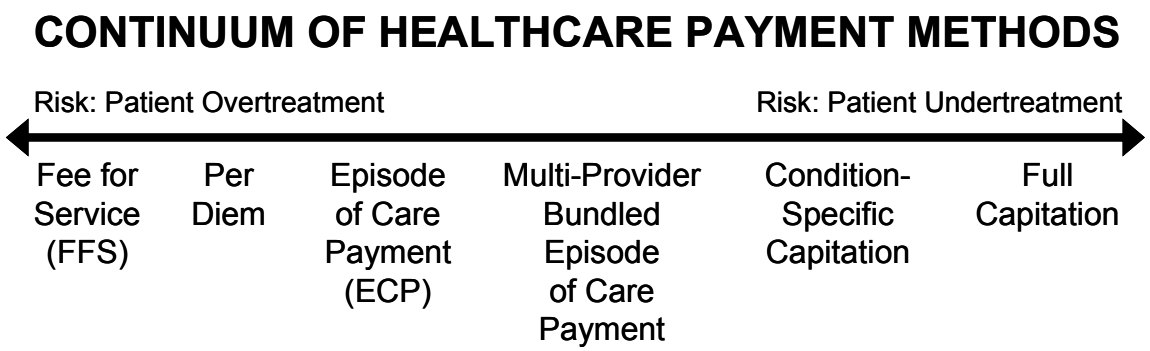


Figure 1

1. **Fee for Service (FFS).** A provider is paid a fee for each specific service rendered.
2. **Per Diem.** A provider is paid a fee for each day of care, covering all services rendered during that day.
3. **Episode of Care Payment (ECP).** A provider is paid a fee for all services rendered during a single episode of care or portion of an episode of care. (For example, the DRG prospective payment system currently used for hospitals by Medicare and other payers is an episode of care system, although it only covers the portion of the full episode of care that occurs in the hospital. In addition, surgeons are typically paid a single amount for all services associated with a

particular episode of care, rather than separate fees for surgery and follow-up care.)

4. **Multi-Provider Bundled Episode of Care Payment.** Two or more providers are jointly paid a fee for their combined services rendered during a single episode of care. (The beginning and/or end of the episode of care may also change when multiple providers are included; for example, an "episode of care" payment system for hospitals typically ends upon discharge from the hospital and an "episode of care" payment system for home health services typically begins after hospital discharge, but a bundled hospital/home health episode of care payment would treat hospital discharge as merely a step in a single, longer episode of care.)
5. **Condition-Specific Capitation.** A fee is paid to cover all services rendered by all providers to deal with a particular condition, either on a one-time basis (for short-term conditions) or on a regular, periodic basis (for longer-term conditions, such as chronic diseases).
6. **Capitation.** A regular, periodic fee is paid to cover some or all services rendered by all providers for all conditions affecting a particular patient.

(This structure is adapted from various authors, particularly "Theory and Practice in the Design of Physician Incentives," by James C. Robinson, *Milbank Quarterly*, 79:2, June 2001.)

Most current payment systems are on the left end of this continuum. Payment for hospitals through Medicare has been based on a form of single-provider Episode of Care payment (the prospective payment system (PPS) using DRGs) for over twenty years, but many private health plans still pay on a Per Diem or other basis that is closer to a Fee for Service System. Payment for physicians is still primarily based on Fee for Service. Capitation plans were used heavily in the 1990s under managed care, but are being used less now, although this varies from state to state and from payer to payer.

The Incentives Associated With Different Payment Methods

There is no perfect model, because each system inherently creates incentives and disincentives for the provider, which in turn create risks for the payer and the patient. Payment systems on the left hand side of the continuum have risks of higher costs to payers and overtreatment of patients, while payment systems on the right hand side of the continuum shift the risks of costs to providers, but thereby create risks of undertreatment of patients.

More precisely, payment systems are structured based on whether the payer or provider is at risk for specific variables affecting cost. In a simplified model of the cost to a payer for all of the care associated with a particular patient, the variables affecting cost can be defined as follows (see Figure 2):

The patient has some number of conditions requiring care (including preventive care for conditions which have not yet been experienced). For each of those conditions, the patient may have one or more episodes of care (in the case of heart disease, for

VARIABLES CONTRIBUTING TO THE COST OF CARE

$$\frac{\text{Cost}}{\text{Patient}} = \frac{\text{Cost}}{\text{Process}} \times \frac{\text{\# Processes}}{\text{Service}} \times \frac{\text{\# Services}}{\text{Episode of Care}} \times \frac{\text{\# Episodes of Care}}{\text{Condition}} \times \frac{\text{\# Conditions}}{\text{Patient}}$$

Figure 2

example, a patient may have multiple heart attacks or require readmission to the hospital for complications of an earlier episode of care). For each episode of care, there will likely be multiple services provided, often by different providers. And even within each service provided, there may be multiple steps or processes involved in providing that service. Each process/service has a cost associated with it.

The total costs of care for a patient will be higher if any one of these variables increases. Even if a provider delivers a particular process step at lower cost, if more process steps are provided for a particular service, if more services are provided for a particular episode of care, etc., then the total cost of care for that patient will be higher.

The different methods of payment assign the risk for the different variables in this equation to either the payer or the provider (see Figure 3). Shifting the risk to the provider reduces the risk of overtreatment and higher costs. However, in the process, it creates a risk to the patient of undertreatment.

VARIABLES FOR WHICH THE PROVIDER IS AT RISK UNDER ALTERNATIVE PAYMENT SYSTEMS

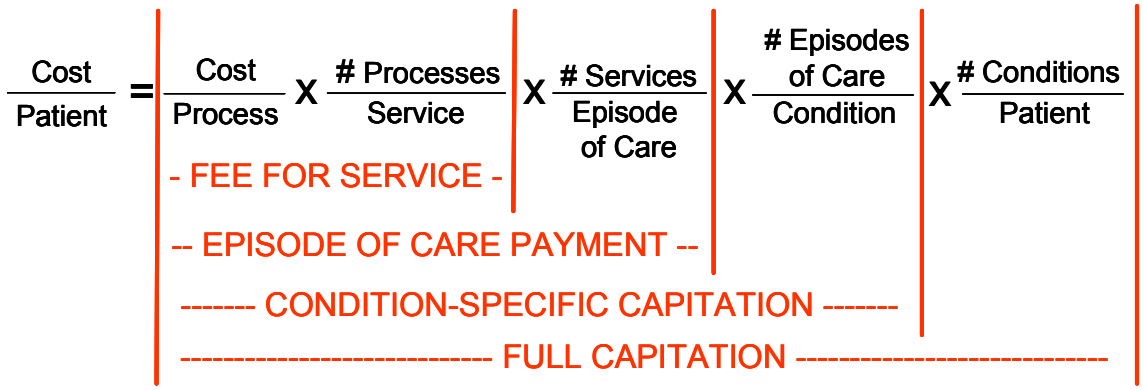


Figure 3

- For example, fee for service payment defines a specific amount for a particular service, regardless of how many or how few process steps a provider may be required to perform. It is generally agreed that the fee-for-service system creates significant incentives for overtreatment. However, within any given service, there is still the risk to the patient that they will not receive all of the processes of care that they should, which is what has led to recent pay-for-performance initiatives

to encourage fee-for-service providers, such as physicians, to provide more of the desired processes of care.

- Episode-of-care payment shifts the risk of the number of services for any episode of care to the provider (or group of providers), but also thereby creates a risk that the patient will receive fewer services than appropriate.
- Condition-specific capitation creates an incentive for a provider to reduce the number of episodes of care;
- Full capitation creates an incentive for a provider to prevent the occurrence of illnesses as well as to treat them more efficiently, but puts the provider at risk if they have patients who are sicker than average, and creates the risk that patients will be under-treated in ways that will affect costs in the long run (see Section II-E).

There is growing interest in payment methods in the middle of the continuum – staying away from full Capitation systems (because of the significant risk they place on providers), but also moving away from Fee-for-Service systems (because of the significant risk of high costs they place on payers) toward Episode-of-Care (ECP) systems, from single provider ECP systems to multi-provider ECP systems, and to broader definitions of the episode of care. The goal has been to create systems that avoid imposing insurance risk on providers (i.e., having providers absorb the differences in costs resulting from differences in the types of patients and their needs), but giving providers more responsibility for managing the full range of costs and outcomes of treatment for patients with similar needs.

Offsetting the Risks and Disadvantages of Alternative Methods

Each variable that is *in*cluded within a single payment amount creates a risk that the provider receiving the payment will undertreat or exclude patients that have high values on that variable (e.g., patients who need an above-average number of services per episode of care) in order to reduce their costs in comparison to the payment. Each variable that is *ex*cluded from a single payment amount creates the risk of overtreatment, i.e., that providers will seek additional patients, episodes of care, etc. beyond what otherwise might be necessary, in order to increase the total amount of revenue they receive.

Therefore, within a particular payment structure, controls or incentives can be developed to counteract these risks. For example, in an Episode of Care payment system, one set of controls and incentives could be developed to insure that important care processes are not ignored as part of the episode of care, and another set of controls and incentives could be developed to discourage providers from providing episodes of care to patients who do not need them.

Conceptually, there are several different types of controls and incentives which can be developed:

1. **Mandates**, i.e., imposing requirements on providers that certain things be done or prohibitions against doing things in order to receive payment, along with mechanisms for reviewing the level of compliance with those requirements or prohibitions (e.g., audits to insure that required processes of care are actually delivered to a particular patient to insure undertreatment did not occur);
2. **Non-Financial Incentives**, i.e., publicly reporting on providers' performance (e.g., reporting on the frequency with which providers deliver desirable processes of care to patients); and
3. **Financial Incentives**, i.e., providing payment rewards or penalties to providers based on their performance (e.g., providing bonuses for greater compliance with specific processes of care or for better patient outcomes).

C. Types of Patients/Conditions

Different types of payment may be appropriate for different types of patients and conditions. Four broad categories of patients and conditions can be defined for considering alternative payment structures. (These categories are drawn from "Overview of a Reconfigured Health System," by Harold S. Luft, presented to the Council on Health Care Economics and Policy at the Thirteenth Princeton Conference on Reinventing Health Care Delivery in the 21st Century, May 24-25, 2006):

1. **Care of Major Acute Episodes.** This includes conditions such as heart attack, stroke, premature delivery, newly diagnosed invasive cancer, or major trauma, and is characterized by the patient needing a complex mix of often-expensive interventions within a relatively brief period of time.
2. **Care of Chronic Conditions.** This includes conditions such as diabetes, hypertension, heart failure, asthma, etc., but excludes the acute exacerbations of the condition that result in a Major Acute Episode.
3. **Care of Minor Acute Episodes.** This includes minor wounds, normal childbirth, minor respiratory diseases, etc. Some conditions may be self-limiting or may not even require treatment, but some may be the early manifestation of something more serious or potentially more serious.
4. **Preventive Care.** This includes immunizations, screening tests, counseling, etc. designed to prevent chronic conditions and some acute episodes.

Each of these categories encompasses a very diverse range of conditions. For example, some have suggested that pregnancy and childbirth should be considered as a separate category, since in some cases it may be a "major acute episode" and in other cases it is more of a "minor acute episode," and since many aspects of prenatal and postpartum maternal and infant care are preventive in nature. However, the issue for this paper is not whether these different conditions require different kinds of *care*, but whether the method of *payment* for care should be different.

The categories are also inherently overlapping. For example, a person with a chronic disease will not only need ongoing care for that chronic condition, but care of

major acute episodes (whether related to the chronic condition or not), care of minor acute episodes (whether related to the chronic condition or not), and care to prevent other illnesses.

In the case of Chronic Conditions, some have suggested that a distinction should be made between people with chronic conditions that are "stable" or "routine," and those with chronic conditions which are "unstable," "advanced," or "complex," or where the patient is sick enough that death within a year "would not be a surprise." For example, Joanne Lynn and David Adamson have suggested that elderly people with chronic, progressive, and eventually fatal illness should be considered separately from individuals with chronic conditions whose disease can be successfully managed indefinitely. They further identify three different trajectories among the elderly with chronic conditions:

- A short period of evident decline (typical of cancer);
- Long-term limitations with intermittent exacerbations and sudden dying (typical of organ system failure); and
- Prolonged dwindling (typical of dementia, disabling stroke, and frailty).

(This tripartite structure is from "Living Well at the End of Life: Adapting Health Care to Serious Chronic Illnesses in Old Age," by Joanne Lynn and David M. Adamson, RAND Health, 2003.)

These categories likely require different types of services and incur different kinds of costs (see Sections II-D and II-E) than the other categories, particularly long-term care, hospice and palliative care, etc. However, the key issue for this paper is whether the method of *payment* for care should be different.

D. Types of Costs and "Bundling" of Payment

For purposes of payment, there are several major types of costs which contribute to the overall cost of care, but which are affected by different sets of forces. These types of costs are being paid for separately under most current payment systems, but they could also be "bundled" together. Six major types of costs include:

1. Primary Care Physician Services
2. Specialist Physician Services
3. Diagnostic Services (e.g., lab tests, radiology, etc.)
4. Drugs and Medical Devices
5. Short-Term Non-Physician Services and Facilities (e.g., hospitals, home health agencies, rehabilitation facilities, etc.)
6. Long-Term Non-Physician Services and Facilities (e.g., nursing homes, assisted living services, etc.)

These different types of costs can represent very different proportions of the total costs of care for different patients/conditions.

Payment systems can either pay for these costs separately, or pay for them in bundles. For example, currently, hospital DRG payments typically cover diagnostic services, drugs and medical devices, and hospital-based services (Types 3, 4, and 5 above), but not physician services. Capitation systems may "carve out" some of these costs and pay for them separately; for example, medical capitation is limited to costs of medical services, whereas long-term care capitation includes long-term care services as well. (See, for example, "Aligning Incentives in the Context of Biomedical Innovation," by James C. Robinson, presentation at the National Pay for Performance Summit, February 16, 2007, for discussion of how device costs and physician costs can be either bundled into or carved out of alternative payment structures.)

E. Indirect and Long-Run Costs

Most discussions of health care costs focus on the short-term payments made to providers for healthcare services associated with a particular patient. However, there are really four major categories of costs that should be considered in examining the impacts of different methods of payment:

1. **Short-Run Direct Costs.** This includes the spending by a healthcare provider for immediate services. For example, the payment made to a hospital to treat an individual's pneumonia would be a short-run direct cost.
2. **Short-Run Indirect Costs.** This includes the cost of lost time from work or other activities by an individual while receiving healthcare services. For example, the patient's lost wages or lost productivity while in the hospital for treatment of pneumonia would be a short-run indirect cost. It may also be extended to include the costs associated with time required from caregivers (e.g., if the child of a fragile, chronically ill parent needs to take time off from work or leave the workforce entirely in order to provide care).
3. **Long-Run Direct Costs.** This includes the spending by healthcare providers in the future which is caused or influenced in some fashion by the services (or lack of services) provided today (i.e., the short run). For example, if the failure of an individual to receive pneumonia vaccine today results in that individual contracting pneumonia in the future, the treatment of that future pneumonia is a long-run direct cost of the lack of pneumonia immunization.
4. **Long-Run Indirect Costs.** This includes the cost of lost time from work or other activities in the future which result in some fashion from the services (or lack of services) provided during the short-run.

Since a dollar in the future is worth less than a dollar in the present, one cannot directly compare the costs in categories 1 & 2 with the costs in categories 3 & 4 without computing the "present value" of the latter costs (which in turn requires an assumption about inflation and/or interest rates).

In order to properly compare the costs of one payment policy versus another, one should ideally estimate all four categories of costs (which requires converting indirect

costs such as time saved or lost into dollars), compute the present value of the future costs, and sum them together, i.e.,

Total Cost = Short-Run Direct Costs +
Short-Run Indirect Costs +
Present Value of Long-Run Direct Costs +
Present Value of Long-Run Indirect Costs

For example, creation of an immunization program would increase short-run direct costs (and might even increase short-run indirect costs because of the time involved for people to get an immunization), but if it would prevent a communicable disease, it would reduce long-run direct and indirect costs. Whether total costs would be higher or lower would depend on whether the number of people immunized and the cost of immunization (the short run costs) are higher or lower than the number of people who would otherwise get sick in the future and the cost of treating them (the long-run costs).

F. Number and Types of Payers and Providers

Multiplicity of Payers

In any given health care market, there are multiple payers, using both public sources of funds (Medicare and Medicaid), and private sources (private insurance plans, third-party administrators, and self-pay individuals). Each payer typically has different methods of paying providers. Any given provider may face significantly different incentives and disincentives for the care of patients with similar conditions depending on which payer is paying for a patient's care.

In addition, the different categories of costs described in Section II-E above are generally not incurred by the same payer. For example, an investment in preventive care for a working age adult made by an employer and its health plan may increase costs for that employer/health plan but reduce costs for Medicare (or another employer/health plan) in the future. If an insured individual travels a longer distance to use a provider that charges less for care, the individual will incur the higher costs of travel while the cost of care to the individual's health plan declines.

Multiplicity of Providers

The number and types of providers vary significantly from region to region, which affects the range of choices available to payers and patients. Small, rural areas may have few physicians and a single hospital, whereas large, urban areas will have many physicians, multiple hospitals, and a range of alternative providers (clinics, urgent care centers, specialty hospitals, etc.)

Where multiple providers are available, individual patients often receive care services from multiple providers even within a single episode of care or short period of time. (For example, recently released research shows that among Medicare beneficiaries, the average patient saw two primary care physicians and five specialists, working in a

median of four practices, over the course of a year. Patients with chronic conditions saw a larger number of physicians and physician practices. See "Care Patterns in Medicare and Their Implications for Pay for Performance," by Hoangmai H. Pham, Deborah Schrag, Ann S. O'Malley, Beny Wu, and Peter B. Bach, *The New England Journal of Medicine*, 356:11, pp. 1130-1139, 2007.)

G. Performance Categories for Health Care Systems

In its 2006 report, *Rewarding Provider Performance*, the Institute of Medicine's Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs defined three broad categories of performance that payment systems should seek to advance in health care systems:

1. **Clinical Quality**, which encompasses effectiveness, safety, timeliness, and equity;
2. **Patient-Centeredness**, an attribute of care that reflects the informed preferences of the patient and the patient's significant others, as well as timeliness and equity; and
3. **Efficiency**, defined as achieving the highest level of quality for a given level of resources.

Within the clinical quality category, there are two fundamentally different types of measures which can be used to assess performance and potentially to modify payments to providers:

1a. **Process Measures**, i.e., measures of the specific procedures or tasks carried out by providers or patients, e.g., administration of drugs, examinations or testing for specific issues, etc.

1b. **Outcome Measures**, i.e., measures of the health or quality of life of the patient, e.g., death, disability, etc.

Within the patient-centeredness category, there are some conditions where multiple care options exist that involve significant tradeoffs affecting the patient's quality and/or length of life. Decisions about this "preference-sensitive" care cannot be based on clinical guidelines alone, but need to reflect the patient's personal values and preferences (see "Preference-Sensitive Care," Dartmouth Atlas Project, 2007).

III. Problems With Current Healthcare Payment Systems

At the risk of oversimplifying, one can define five major areas where the performance of healthcare systems can affect patient outcomes and/or healthcare costs (see Figure 4):

1. Prevention of Illness and the Progression of Illness
2. Accuracy of Diagnosis/Prognosis
3. Appropriateness of Care
4. Avoidance of Adverse Events
5. Follow-Up to Care

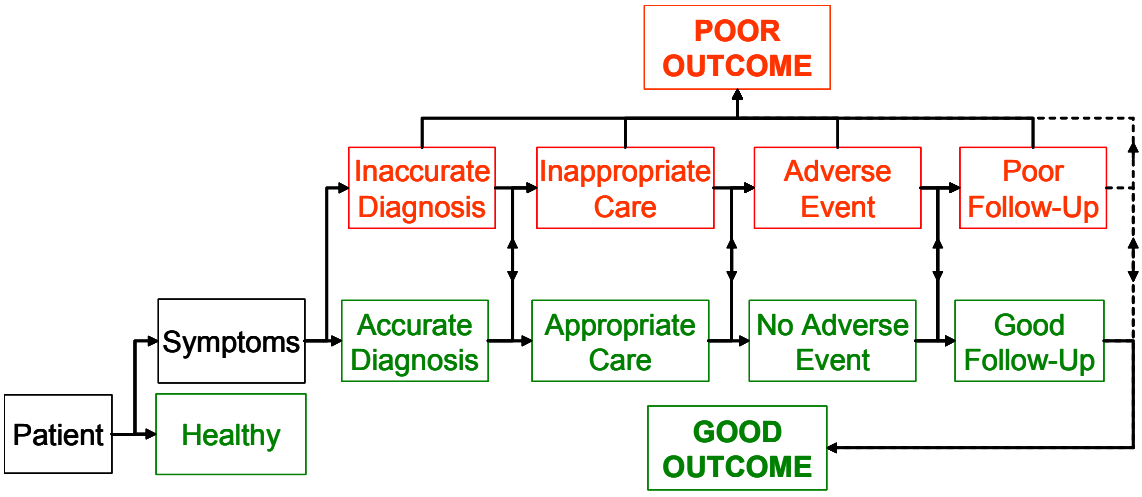


Figure 4

In each of these areas, current payment systems create penalties and disincentives for improved outcomes and/or lower costs. In addition, payment systems can more generally discourage efficiencies in care or increase costs of care.

The following sections attempt to summarize the problems that exist in each area in order to provide a foundation for the sections that follow.

A. Prevention of Illness and the Progression of Illness

One of the purposes of the healthcare delivery system, particularly through primary care physicians, is to help prevent illnesses (or disease states) from occurring or worsening. In addition, depending on the illness, patient adherence and the physical environment (e.g., public health factors) can be significant factors in the success of prevention efforts.

PROBLEM 1.1: Current fee for service systems generally do not pay adequately (or at all) for many elements of primary care and preventive care.

In addition, low payment levels are believed to be discouraging physicians from entering primary care vs. specialty care.

PROBLEM 1.2: Current fee for service systems generally do not pay adequately (or at all) for the more complex care issues associated with the elderly and other people with chronic conditions.

PROBLEM 1.3: Patients generally do not have a financial incentive to adhere to prevention and disease management recommendations that could reduce health care costs.

PROBLEM 1.4: Payers may not have an incentive to invest in preventive care if the payoff in terms of better health and lower costs occurs in the (distant) future and may accrue to other payers.

B. Accuracy of Diagnosis/Prognosis

Once an illness has occurred, prompt and accurate diagnosis (i.e., determining what condition(s) the patient has) and prognosis (i.e., projecting the likely course of the condition(s) with and without treatment) is essential to appropriate care. Inaccurate diagnoses and prognoses may result in (a) unnecessary or inappropriate care, with the associated expenses and risk of adverse effects, and/or (b) the failure to apply appropriate care in a timely fashion, potentially leading to poorer outcomes. This area appears to have been subject to the least research.

PROBLEM 2.1: Fee-for-service systems may not pay adequately for the time needed by providers to make an accurate diagnosis/prognosis and to discuss it with patients, particularly in complex or unusual cases.

Providers can have a financial incentive to order more diagnostic tests by other providers rather than spend more time with a patient to explore symptoms more carefully.

PROBLEM 2.2: Under fee-for-service systems, providers are not compensated for investments in information systems that could assist in making an accurate diagnosis/prognosis.

PROBLEM 2.3: Under fee-for-service systems, providers are not financially penalized for ordering more tests, regardless of whether they are necessary to make an accurate diagnosis/prognosis.

Malpractice concerns may encourage overtesting, but fee-for-service payment eliminates the financial penalty for the provider in doing so.

PROBLEM 2.4: Under fee-for-service systems, providers are paid for conducting tests regardless of whether they are necessary to make an accurate diagnosis/prognosis.

PROBLEM 2.5: Under fee for service systems, providers making diagnoses/prognoses get paid regardless of the accuracy of the diagnosis/prognosis.

PROBLEM 2.6 Current payment systems can financially reward providers for making overly optimistic prognoses of the likelihood of survival or the benefits of treatment.

For example, overly optimistic prognoses can lead patients in the final stages of terminal illnesses to pursue expensive treatment rather than palliative care.

PROBLEM 2.7: Under fee-for-service systems, providers that supply testing information used in making diagnoses/prognoses are paid regardless of the accuracy of their collection and interpretation of data.

For example, pathologists play a crucial role in determining whether a malignancy is present and in classifying the type and stage of a malignancy, which in turn is critical to a determination as to whether and what type of treatment is appropriate. Pathologists are paid for analyzing tissue and serum samples even if the analysis or interpretation is found later to be inaccurate. There is some evidence of significant rates of errors in testing.

PROBLEM 2.8: Patients (and/or families) may request/demand expensive tests that may not be appropriate but increase the cost of diagnosis/prognosis, without any financial penalty to the patient for doing so.

C. Appropriateness of Care

"Appropriateness" can be loosely defined as "not too much," "not too little," and "the right" care, i.e., the avoidance of overtreatment, undertreatment, and mistreatment. In addition, the most appropriate treatment may be no treatment at all, or self-treatment by the patient rather than treatment by a separate provider.

This area has been the focus of the largest body of research and discussion in terms of the influences of payment systems.

PROBLEM 3.1: Current episode of care payment systems are generally based on the average costs that providers report incurring in delivering care, rather than the costs associated with providing high-quality, efficient care.

Depending on the level of quality and efficiency of the care on which cost estimates are based, the payment levels in episode of care payment systems (e.g., DRGs) may be higher or lower than necessary to cover the costs of high-quality care.

PROBLEM 3.2: Many healthcare providers explicitly rely on payments that significantly exceed costs for certain conditions/patients in order to offset losses incurred on other conditions/patients where payments do not cover the costs of care.

As a result, there is resistance by providers to reducing charges (i.e., costs to payers) where it is feasible to do so because of the provider's dependency on the cross-subsidy involved. At the same time, this creates incentives for the creation of specialty hospitals and clinics focusing just on the high-margin patients and conditions.

PROBLEM 3.3: Certain types of providers or services (e.g., nurse practitioners, pharmacists, etc.) may not be covered separately under payment systems, even though they are licensed to provide the care, reducing the likelihood that they will be used even if they are more appropriate than providers/services which are covered.

For example, although close attention to appropriate medication management during and following inpatient care has been shown to improve outcomes and reduce readmissions, pharmacists and pharmacy services are not separately paid for under most payment systems.

PROBLEM 3.4: Fee-for-service systems financially penalize providers for eliminating services that do not improve outcomes.

PROBLEM 3.5: Fee for service payment systems reward providers for providing unnecessary services and low-value services.

As it is often described, the fee-for-service payment system is "weighted toward intervention."

PROBLEM 3.6: Many payment systems not only provide higher reimbursements for more expensive procedures, but higher margins over providers' costs.

Studies have shown that relatively lower reimbursement is provided for services involving primarily cognitive skills (e.g., patient assessment and counseling, prevention services) than services involving procedural skills (e.g., surgery and other invasive procedures), which also involve expensive equipment and facilities.

PROBLEM 3.7: Payment is made to whichever inpatient care facility is chosen by a patient's physician (or by the patient based on where the physician practices), in many cases without regard to cost and/or quality.

PROBLEM 3.8: For choices about preference-sensitive care, payment rates can create financial incentives and disincentives for providers to influence particular choices by patients.

For example, if a patient has a choice between medical management and surgery to address a particular condition, a surgeon may have a financial disincentive to explain the benefits of medical management vs. surgery in a neutral fashion.

PROBLEM 3.9: Providing palliative care, rather than treatment, to patients in the final stages of terminal illnesses can reduce costs and improve patient comfort, but current payment systems often reward expensive treatment measures in the final stages of life.

This problem is also related to the problems of inaccurate prognosis described earlier – a provider may be rewarded financially for providing the treatment selected in response to an overly optimistic prognosis.

PROBLEM 3.10: Payment systems generally pay for services regardless of whether all of the processes recommended in clinical practice guidelines are performed by the provider.

Despite the presumed incentives in the fee-for-service system for physicians to provide maximum treatment, studies have shown that patients receive only about half of the care processes viewed as desirable or essential. This may be because these processes are not reimbursed separately (see Section II-B).

PROBLEM 3.11: Episode of care payment systems can financially penalize providers for adding components of care that could improve long-term outcomes but increase short-term direct costs.

PROBLEM 3.12: Episode of care payment systems financially penalize providers for accepting patients with above-average treatment needs within a particular diagnosis/severity category and for uncontrollable costs of drugs and medical devices, unless the patient's care is expensive enough to justify an outlier payment.

PROBLEM 3.13: Capitation payment systems financially penalize providers for accepting patients with above-average treatment needs and for uncontrollable costs of drugs, medical devices, etc.

PROBLEM 3.14: Payment systems reinforce fragmentation of care by paying multiple providers for elements of the same episode of care for the same patient, regardless of whether the care is coordinated or duplicative.

PROBLEM 3.15: Different providers (e.g., hospitals and physicians) are generally paid separately and through different payment systems with different incentives.

A hospital seeking to improve quality or reduce costs of inpatient acute care may not be able to do so without the cooperation of physicians (who may be financially penalized for doing so under a fee-for-service payment system). Physicians who seek to improve quality of inpatient acute care may not be able to do so without the cooperation of the hospital (which may be financially penalized under a per diem or DRG-type system for doing so).

PROBLEM 3.16: For hospital care, physicians order the use of drugs or devices, but the costs associated with those drugs and devices are typically incurred by the hospital and must be absorbed within the payment made to the hospital, not by the physician.

PROBLEM 3.17: Patients and/or families may request/demand expensive drugs, devices, or procedures that may not be appropriate but increase the cost of care, without any financial penalty for doing so.

PROBLEM 3.18: Many payers do not have mechanisms for encouraging or directing patients to providers which provide care at lower cost (for the same quality) or higher quality (at the same cost).

Because of this, there is no financial incentive for a provider to charge a payer less for care since there may be no practical way for the provider to offset the lost revenue with a greater volume of patients.

PROBLEM 3.19: Payment systems do not explicitly reward providers for reducing indirect costs of care, such as length of time away of work (e.g., a worker's length of stay in the hospital, time spent waiting for a doctor's appointment or testing, etc.).

D. Avoidance of Adverse Events

A considerable literature has developed regarding the frequency and causes of adverse events due to provider errors or neglect. However, there have been relatively few efforts to study the impacts of such adverse events on costs and payments, and relatively few explicit changes in payment systems to address them.

PROBLEM 4.1: Under most payment systems, providers are paid regardless of whether patients experience adverse events under their care.

PROBLEM 4.2: Under most payment systems, providers are paid more for patients experiencing adverse events, particularly serious adverse events resulting in multiple complications.

Although some studies have reported that the increased payments to hospitals for adverse events are not sufficient to cover the increased costs of care, more recent research suggests that hospital margins may be negatively impacted by reducing adverse events that occur at low rates. Physicians paid under fee-for-service arrangements will likely receive additional fees for additional care of patients who experience adverse events.

PROBLEM 4.3: Providers may benefit financially if they can shift the care of patients experiencing adverse events to other providers.

For example, long-term care facilities are paid for care regardless of whether adverse events occur that may lead to hospitalization or other forms of health care; moreover, provisions for "bed holding payments" can increase payments to long-term care facilities when patients experience adverse events that require (or can qualify for) hospitalization.

E. Follow-Up to Care

For many types of conditions, the full course of care does not occur within the boundaries of a single provider. For example, a hospital patient may be discharged to home health care for certain kinds of therapies. Moreover, in general, following the completion of hospital care or care by a specialist, patients are expected to comply with post-discharge instructions under the supervision of their primary care physician. Some patients need long-term care in nursing homes, in assisted living facilities or programs, or in hospice programs following acute care.

PROBLEM 5.1: Fee-for-service systems do not pay providers adequately for detailed discharge planning services.

PROBLEM 5.2: Fee-for-service systems generally do not pay providers more to manage the needs of patients with complex conditions after discharge from the hospital or to proactively work to encourage and assist the patient in complying with post-discharge instructions.

PROBLEM 5.3: Although poor medication compliance is a major contributor to hospital readmissions, most payment systems do not compensate pharmacists for effective medication management (either in addition to or instead of a primary care physician).

PROBLEM 5.4: Most payment systems pay providers regardless of the quality of the discharge planning services.

PROBLEM 5.5: Providers of follow-up care are paid for services regardless of whether they follow recommended processes or have poor outcomes.

PROBLEM 5.6: Providers are paid regardless of whether problems occur after leaving their care that could reasonably have been prevented while under their care.

PROBLEM 5.7: Providers may be rewarded financially if a patient experiences a problem after discharge from care (that could have been

prevented during care) and then requires additional care by that provider.

PROBLEM 5.8: Capitation payment systems financially penalize providers for care of patients with above-average treatment needs and for uncontrollable costs of drugs, medical devices, etc.

PROBLEM 5.9: If providers are paid separately for their individual components of a sequence of care, earlier-stage providers may be financially rewarded (and later-stage providers penalized) if the earlier-stage providers discharge/transfer patients earlier or with more significant needs.

PROBLEM 5.10: Patients generally do not experience financial penalties when their failure to adhere to post-discharge care recommendations results in the need for additional, costly care.

PROBLEM 5.11: Payment systems may reward providers for increasing indirect costs of care, e.g., by imposing greater responsibilities for care on patients or family caregivers.

F. Efficiency and Cost Reduction

PROBLEM 6.1: Many payers are reluctant to make changes in the payment levels for individual services or episodes of care, preferring to make across-the-board adjustments in a provider's payment levels, which leads to distortions in payments vs. costs.

For example, DRG systems are based on relative weights for individual diagnoses times a base rate for the provider. Many payer-provider negotiations are limited to changing the amount of the base rate, rather than changing the weights for individual diagnoses; as a result, a provider that can deliver a particular service at lower cost cannot, in effect, charge less for that service without charging less for all services (or for a range of services that the payer groups together for adjustment).

PROBLEM 6.2: Some payers prohibit paying for multiple procedures on the same day or during the same patient visit, which can discourage efficient and coordinated delivery of care.

PROBLEM 6.3: Requirements that care be delivered by a physician during an office visit discourage the use of lower-cost health professionals and the use of communications techniques such as email and phone calls that are lower cost and easier for patients.

PROBLEM 6.4: Payers (purchasers and plans) do not make patients aware of ways to reduce costs, or if they do, patients may view them as efforts to lower quality of care.

PROBLEM 6.5: The existence of multiple methods of payment by different payers imposes significant administrative costs on providers, which increases the costs of care and reduces the time and resources available to devote to direct patient care.

Some payment systems are very different – for example, one payer may pay a hospital based on DRGs, while another may make per diem payments – while others may appear superficially similar, but are different in specific details (particularly recently with the growth in pay-for-performance incentives). Concerns about anti-trust issues can discourage payers and/or providers from agreeing on common systems of payment with common incentives and administrative requirements.

PROBLEM 6.6: The existence of multiple methods of payment by different payers creates different sets of incentives for providers, which complicates the planning and management of patient care.

IV. Concerns Regarding Current Pay-for-Performance Systems

A variety of concerns have been raised about the pay-for-performance systems and demonstrations which have been established in an effort to address some of the problems described in Section III. The following is a list of some of the major concerns that have been raised regarding these systems.

CONCERN 1: Current pay for performance systems do not directly address many of the problems described in Section III.

CONCERN 2: The amount of performance bonuses and penalties in most pay for performance systems is relatively small, reducing the likelihood they will overcome the problems they are intended to address.

CONCERN 3: When pay for performance programs create funding for bonuses in one type of service by reducing base payments across the board, it may force providers to cut back services in other areas, or encourage providers to shift costs by increasing charges to other payers.

CONCERN 4: If pay for performance systems provide additional funding for high or improved performance without reductions in base payment rates or penalties for poor performance, total costs may increase.

CONCERN 5: Pay for performance systems that provide rewards based on the level of compliance with recommended processes may not result in improved outcomes.

CONCERN 6: Pay for performance systems that provide rewards based on compliance with recommended processes may unintentionally deter innovation and experimentation with new processes that achieve better outcomes.

CONCERN 7: The reductions in a provider's net revenues from implementing a quality improvement initiative may exceed the payment incentives provided through a pay for performance system for that initiative.

CONCERN 8: Rewarding only the best-performing providers does not provide resources to cover the costs that lower-performing providers may incur in making efforts to improve.

CONCERN 9: Rewarding improvement on composite performance measures based on averages of performance on sub-measures may result in improvements on the easiest-to-improve sub-measures while performance worsens on other sub-measures.

CONCERN 10: Measures are only available for a subset of the processes that are important to good outcomes; pay for performance systems that reward a subset of processes may divert attention from other important processes.

CONCERN 11: Process measures in pay for performance systems are not applicable to all patients with a particular diagnosis, and are not available for many diagnoses.

CONCERN 12: Providing incentives based on outcomes (or even some processes) can create incentives for providers to exclude or undertreat patients who are likely to have poor outcomes or to be non-compliant with treatment regimes, or to overtreat patients who are likely to have better outcomes or be more compliant.

CONCERN 13: Because of the fragmentation of care, it is often difficult or impossible to clearly assign responsibility for performance or lack of performance to a particular provider.

This makes it difficult to award or apportion incentive payments to particular providers.

CONCERN 14: A provider's costs of documenting compliance with processes and/or achievement of outcomes may exceed the amount of payment incentives the provider receives based on those performance measures.

CONCERN 15: Different pay for performance systems have different standards of performance, different incentives, and different reporting requirements, which increases administrative costs for providers and makes it difficult for them to plan and manage care consistently for patients who have similar conditions but different payers.

V. Potential Goals for Effective Value-Based Healthcare Payment Systems

In order to address the problems described in Section III and avoid the concerns about existing pay-for-performance systems described in Section IV, the following are twelve potential goals that revised payment systems could seek to achieve.

GOAL 1: Payment systems should enable and encourage providers to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner.

This goal is intended to address Problems 1.1, 1.2, 2.1, 3.1, 3.2, 5.1, 5.2, and 6.1, and Concerns 1 and 2.

GOAL 2: Payment systems should support and encourage investments, innovations, and other actions by providers that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs.

This goal is intended to address Problems 2.2, 3.3, 5.3, 6.2, and 6.3, and Concerns 6, 7, and 8.

GOAL 3: Payment systems should not encourage or reward overtreatment, use of unnecessarily expensive services, unnecessary hospitalization or re-hospitalization, provision of services with poor patient outcomes, inefficient service delivery, or encouraging choices about preference-sensitive services that are not compatible with patient desires.

This goal is intended to address Problems 2.3, 2.4, 3.4, 3.5, 3.6, 3.7, 3.8, and 3.9, and Concerns 4 and 5.

GOAL 4: Payment systems should not reward providers for undertreatment of patients or for the exclusion of patients with serious conditions or multiple risk factors.

This goal is intended to address Problems 3.10, 3.12, 3.13, 5.4, 5.5, and 5.8, and Concerns 9, 10, 11, and 12.

GOAL 5: Payment systems should not reward provider errors or adverse events.

This goal is intended to address Problems 2.5, 2.6, 2.7, 4.1, 4.2, 5.6, and 5.7.

GOAL 6: Payment systems should make providers responsible for quality and costs within their control, but not for quality or costs outside of their control.

This goal is intended to address Problems 3.12 and 3.13 and Concern 13.

GOAL 7: Payment systems should support and encourage coordination of care among multiple providers, and should discourage providers from shifting costs to other providers without explicit agreements to do so.

This goal is intended to address Problems 3.14, 3.15, 3.16, 4.3, and 5.9, and Concern 13.

GOAL 8: Payment systems should encourage patient choices that improve adherence to recommended care processes, improve outcomes, and reduce the costs of care.

This goal is intended to address Problems 1.3, 2.8, 3.17, 3.18, 5.10, and 6.4.

GOAL 9: Payment systems should not reward short-term cost reductions at the expense of long-term cost reductions, and should not increase indirect costs in order to reduce direct costs.

This goal is intended to address Problems 1.4, 3.11, 3.19, and 5.11.

GOAL 10: Payment systems should not encourage providers to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers.

This goal is intended to address Problem 3.2 and Concern 3.

GOAL 11: Payment systems should minimize the administrative costs for providers in complying with payment system requirements.

This goal is intended to address Problem 6.5 and Concerns 14 and 15.

GOAL 12: Different payers should align their standards and methods of payment in order to avoid unnecessary differences in incentives for providers.

This goal is intended to address Problem 6.6 and Concern 15.

VI. Creating a Value-Based Healthcare Payment System

This Section and the following three Sections (Sections VII, VIII, and IX) define specific issues that need to be resolved in order to achieve the goals defined in Section V, as well as specific options for resolving them.

This Section deals with issues associated with Question #1 defined in the Introduction: *What changes should be made in current healthcare payment systems in order to eliminate (or significantly reduce) the current penalties and disincentives for higher-quality, lower-cost healthcare?*

Four Groups of Patients/Conditions

Because the nature of the providers and care are so different across the four categories of patients/conditions defined in Section II-C, the core payment issues are defined and discussed separately for each of them:

- Subsection VI-A addresses how payment could be structured for *care of major acute episodes*, i.e., conditions such as heart attack, stroke, premature delivery, newly diagnosed invasive cancer, or major trauma, that are characterized by the patient needing a complex mix of often-expensive interventions within a relatively brief period of time.
- Subsection VI-B addresses how payment could be structured for *care of chronic conditions*, i.e., conditions such as diabetes, hypertension, heart failure, asthma, etc.
- Subsection VI-C addresses how payment could be structured for *care of minor acute episodes*, i.e., minor wounds, normal childbirth, minor respiratory diseases, etc.
- Subsection VI-D addresses how payment could be structured for *preventive care*, i.e., immunizations, screening tests, counseling, etc. designed to prevent chronic conditions and some acute episodes.

As noted in Section II-C, there are significant difference among patients and conditions even within these four categories, and some of these may warrant differences in payment systems.

Five Categories of Issues

In Part 1 of each subsection, five categories of issues are addressed:

6. What basic method of payment should be used to compensate providers for this type of care;
7. Whether payments for multiple providers should be "bundled" together;
8. How the actual level of payment should be determined;

9. What performance standards should be set and whether incentives for performance should be added to the basic payment method; and
10. Whether specific incentives should be provided to patients regarding choice of providers and participation in care.

Examples of Restructured Payment Systems

In Part 2 of each subsection, an example of a possible payment system is described, incorporating options from each of the issues. The reader may find it helpful to read Part 2 in each subsection first, in order to get a broad overview of the kinds of elements which need to be combined for payment restructuring, before reviewing the specific issues and options in Part 1.

Details of Reward/Incentive Systems

Section VII deals with issues associated with the second key question defined in the Introduction: *What additional rewards or incentives, if any, should be included in healthcare payment systems in order to encourage higher quality, lower-cost healthcare?* Each of the subsections in Section VI asks generally *whether* incentives should be provided, but leaves to Section VII the issues of *how* those incentives should be structured.

Other Issues

Section VIII deals with mechanisms for establishing categories of diagnosis and patient severity, guidelines of care, costs, measures of performance, etc. which are necessary for either basic payment systems or for incentive systems.

And finally, Section IX deals with an overarching critical issue: Regardless of what payment system(s) are defined, what process can be used to facilitate successful implementation by payers?

A. Creating a Value-Based Payment System for Care of Major Acute Episodes

This subsection focuses on how payers should pay for *care of major acute episodes*, i.e., conditions such as heart attack, stroke, premature delivery, newly diagnosed invasive cancer, or major trauma, that are characterized by the patient needing a complex mix of often-expensive interventions within a relatively brief period of time (see Section II-C).

This subsection is divided into 13 different issues within 5 groups that need to be addressed in order to achieve the goals proposed in Section V:

Basic Payment Method

1.1 What basic method should be used to pay providers for care of major acute episodes?

Bundling of Payment

1.2 Should episode-of-care payments to hospitals and to the physicians managing the hospital care for major acute episodes be bundled together into a single payment?

1.3 Should episode-of-care payments to hospitals and to post-acute care providers for major acute episodes be bundled together into a single payment?

1.4 If payments are defined in bundles, should payers allocate bundled payments among providers, or should one accountable provider receive the payment and allocate it to other providers?

1.5 Should there be any restrictions on how profits/losses within a bundled payment are divided among providers?

Payment Levels

1.6 How should the base payment level be determined?

1.7 Should there be any adjustment in payment levels to reflect differences in costs for providers with special characteristics?

1.8 Should payment levels be adjusted for "outlier" cases?

Performance Standards

1.9 What level of service or performance should be required in order to receive the base payment level?

1.10 How should payments be changed when preventable adverse events (errors, infections, etc.) occur?

1.11 Should financial incentives beyond the basic payment level be provided for differences in performance?

Patient Incentives

1.12 How should patients be encouraged to choose high quality/low-cost providers?

1.13 How should patients be encouraged or assisted to adhere to care processes that affect outcomes or costs?

Ways that the payments defined in this section might be modified at the margin to reward or penalize varying levels of performance will be discussed separately, in Section VII.

For each issue, options for resolution are suggested. In most cases, there are many potential options for addressing an issue – an attempt has been made to identify options that differ along major conceptual dimensions, but the specifics of individual options will likely need to be modified or enhanced in order to insure that specific goals and concerns are addressed. In addition, options for a particular issue may not be mutually exclusive.

1. Key Issues and Options

ISSUE 1.1: WHAT BASIC METHOD SHOULD BE USED TO PAY PROVIDERS FOR CARE OF MAJOR ACUTE EPISODES?

See Section II-B for a general description of the basic alternative payment systems.

OPTION 1.1.1: A single prospectively defined Episode of Care Payment (ECP) should be made to cover all of a **hospital's services** associated with an episode of care for a patient, with the amount adjusted for the severity/risk of the patient. Other **non-physician services** (e.g., home health agencies), should be paid in the same way. **Physicians should be paid on a fee-for-service basis** for the services they render as part of the episode-of-care.

OPTION 1.1.2: A single prospectively defined Episode of Care Payment (ECP) should be made to cover all of a provider's services associated with an episode of care for a patient, with the amount adjusted for the severity/risk of the patient. **All providers (hospitals, physicians, home health care agencies, etc.) and all costs (e.g., drugs and medical devices) involved in the episode of care should be paid on this basis**.

This would be conceptually similar to the current PPS/DRG system currently used by Medicare to pay hospitals, although bundling of payment, the determination of the base payment level, etc. could be different, as discussed below. This would be a significant change in payment for physicians.

ISSUE 1.2: SHOULD EPISODE-OF-CARE PAYMENTS TO HOSPITALS AND TO THE PHYSICIANS MANAGING THE HOSPITAL CARE FOR MAJOR ACUTE EPISODES BE BUNDLED TOGETHER INTO A SINGLE PAYMENT?

Currently, most payment systems are designed to pay each provider separately for the services they provide. A "bundled" payment means that a single payment is defined to cover the services of two or more providers, with a goal of aligning incentives for all of the providers.

OPTION 1.2.1: For major acute episodes, separate payments should be defined and made to the hospital and to the physician(s) managing the care.

OPTION 1.2.2: For major acute episodes, a single payment should be defined for both the hospital and the physician(s) managing the hospital care for an episode of care.

ISSUE 1.3: SHOULD EPISODE-OF-CARE PAYMENTS TO HOSPITALS AND TO POST-ACUTE CARE PROVIDERS FOR MAJOR ACUTE EPISODES BE BUNDLED TOGETHER INTO A SINGLE PAYMENT?

OPTION 1.3.1: For major acute episodes, separate payments should be defined and paid to the hospital and any post-acute care providers associated with an episode of care.

OPTION 1.3.2: For major acute episodes, a single payment should be defined for both the hospital and post-acute care providers associated with an episode of care.

ISSUE 1.4: IF PAYMENTS ARE DEFINED IN BUNDLES, SHOULD PAYERS ALLOCATE BUNDLED PAYMENTS AMONG PROVIDERS, OR SHOULD ONE ACCOUNTABLE PROVIDER RECEIVE THE PAYMENT AND ALLOCATE IT TO OTHER PROVIDERS?

OPTION 1.4.1: If payments are defined in bundles, groups of providers should be encouraged to create joint arrangements for receiving and allocating a payment amongst themselves. However, where no such arrangement has been defined, payers should allocate the payment to individual providers based on a standard allocation determined during the process of setting the base payment level.

For example, if the base payment level for inpatient care is set on the assumption that 80% of the payment will cover hospital services and 20% of the payment will cover physician services, then unless the hospital and physician(s) have agreed that one of them (or a third party) will receive the entire payment and make different allocations among the group, the payer would pay 80% of the payment to the hospital and 20% to the physician(s).

OPTION 1.4.2: If payments are defined in bundles, groups of providers should be required to define a single accountable payee for receiving and allocating a payment amongst themselves.

OPTION 1.4.3: In the long run, if payments are defined in bundles, groups of providers should be required to define a single accountable payee for receiving and allocating a payment amongst themselves. However, in the short run, where no such arrangement has been defined, payers should allocate the payment to individual providers based on a standard allocation determined during the process of setting the base payment level. Incentives should be created to encourage groups of providers to create joint arrangements for receiving and allocating a payment amongst themselves.

ISSUE 1.5: SHOULD THERE BE ANY RESTRICTIONS ON HOW PROFITS/LOSSES WITHIN A BUNDLED PAYMENT ARE DIVIDED AMONG PROVIDERS?

PROPOSAL 1.5: If payments are defined and paid in bundles, providers should be free to work out their own arrangements as to how any profits or losses incurred on a bundled payment should be divided amongst them.

Currently, federal law restricts the ability of hospitals to share profits on services with physicians (commonly referred to as "gainsharing"). This law would likely need to be changed to accommodate this proposal.

ISSUE 1.6: HOW SHOULD THE BASE PAYMENT LEVEL BE DETERMINED?

OPTION 1.6.1: For each combination of diagnosis and patient severity for which a separate Episode of Care Payment will be made, providers should propose the amount of payment (i.e., their "price" for the episode of care).

OPTION 1.6.2: For each combination of diagnosis and patient severity for which a separate Episode of Care Payment (ECP) will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should define a recommended set of best-practice services to be covered by the ECP and, where data are available, estimate the current cost for that set of services. Actual ECP levels would be determined through negotiations between providers and payers.

OPTION 1.6.3: For each combination of diagnosis and patient severity for which a separate Episode of Care Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a recommended payment level based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity (i.e., a "suggested price" for the episode of care). Providers would either accept the recommended payment level, or propose a discount below (or premium above) the payment level that they will accept (i.e., their "price" for the episode of care) for that category of patient. Recommended base payment levels should differ from region to region based on the differences in cost-of-living by region, but detailed cost differences should be captured by providers in their discounts/premiums over the standard payment rate.

Options 1.6.1, 1.6.2, and 1.6.3 are each consistent with either a bidding model or a negotiation model of pricing – in each case, the provider proposes a price and the payer would either accept or reject the price. Options 1.6.2 and 1.6.3 would introduce a "starting point" for bidding or negotiations through the recommended payment level.

OPTION 1.6.4: For each combination of diagnosis and patient severity for which a separate Episode of Care Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine the payment level based on a study to estimate the cost of delivering good quality care for that combination of diagnosis and severity. Payment levels should differ from region to region based on the differences in cost-of-living by region. Providers should accept the payment level as payment in full for the care provided to patients in that category.

Establishing a uniform payment level across all providers and payers in a region will likely raise anti-trust concerns. A special ruling from the U.S. Attorney General and state

Attorney(s) General, or legislation, may be needed to provide a safe harbor for such a pricing approach if appropriate benefits can be demonstrated.

ISSUE 1.7: SHOULD THERE BE ANY ADJUSTMENT IN PAYMENT LEVELS TO REFLECT DIFFERENCES IN COSTS FOR PROVIDERS WITH SPECIAL CHARACTERISTICS?

OPTION 1.7.1: Base payment levels for episodes of care should be increased for providers with special characteristics that have been demonstrated to increase the average costs of care, such as teaching hospitals, hospitals and other providers serving large numbers of low-income patients, etc.

OPTION 1.7.2: Base payment levels for episodes of care should not be adjusted for providers with special characteristics; however, separate payments (or explicit premiums on payment levels) should be established by payers in each region to cover these costs.

ISSUE 1.8: SHOULD PAYMENT LEVELS BE ADJUSTED FOR "OUTLIER" CASES?

"Outlier" cases are patients for whom the level of services or costs associated with quality care are significantly higher than for other patients with the same diagnosis and ostensibly the same severity level. Fee-for-service and per diem payments inherently compensate providers more for this additional care, but episode-of-care and capitation systems do not, unless explicit provisions are made to do so. For example, Medicare's inpatient hospital prospective payment system provides an outlier payment to a hospital if its charges/costs of care exceed a certain threshold above the DRG payment for a patient.

OPTION 1.8.1: When a provider documents that its total costs of caring for a patient exceed a certain multiple of the base payment level for that category of patient (based on diagnosis and severity), the provider should receive an additional payment to cover a portion of those costs. (Costs would be based on information provided on actual costs of care, rather than costs computed from charges.)

OPTION 1.8.2: When a provider documents that it was required to provide services significantly beyond the level assumed in computing the base payment level, the provider should receive an additional payment to cover a portion of the documented out-of-pocket costs associated with the additional care.

The distinction between Option 1.8.1 and Option 1.8.2 is that in the latter, the provider documents *services* performed beyond the normally expected level of services, rather than *costs* beyond the normally expected level of costs. (Costs may be higher than expected simply because of a higher cost structure at the provider, rather than because of a higher level of services provided.) Also, in Option 1.8.2, the outlier payment is based on out-of-pocket costs (e.g., medications, etc.) rather than total costs (e.g., allocations of overhead, salaries, etc.).

OPTION 1.8.3: Some adjustment should be made for cases where the level of services required for quality care significantly exceeds typical or expected levels,

if there is evidence that improved outcomes are being achieved through the higher levels of service.

OPTION 1.8.4: No adjustment in payment should be made for patients requiring significantly more services or costs than were assumed in setting the base payment level, but such outlier cases should be documented and used by the payer and provider to adjust the diagnosis/severity categories (e.g., by adding a new severity level) and/or to adjust future base payment levels.

Failure to provide any adjustment could violate Goal 4, by encouraging providers to avoid patients with unusually high care needs that are not effectively captured in the severity adjustment system.

ISSUE 1.9: WHAT LEVEL OF SERVICE OR PERFORMANCE SHOULD BE REQUIRED IN ORDER TO RECEIVE THE BASE PAYMENT LEVEL?

Because of concerns that many patients are not receiving elements of care that have been determined to be appropriate or necessary, most current pay-for-performance systems have an explicit or implicit goal of *encouraging*, but not *mandating*, that providers reach 100% compliance with certain processes that have been demonstrated to improve patient outcomes. However, an alternative approach would be to define processes where 100% compliance is considered *essential* (except where they are clearly contraindicated or where the patient is participating in a clinical trial explicitly to test new processes) and to *require* that those processes be performed in order to receive payment.

OPTION 1.9.1: Payers and/or a public-private collaborative (involving both payers and providers) should define those processes that are considered mandatory for patients in a particular diagnosis/severity category, and providers should only be paid if those processes are delivered, unless there is clear documentation that the processes are contra-indicated for the patient or if the patient is participating in a formal clinical trial of alternative processes.

OPTION 1.9.2: No mandatory processes should be established in order for providers to receive payment.

ISSUE 1.10: HOW SHOULD PAYMENTS BE CHANGED WHEN PREVENTABLE ADVERSE EVENTS (ERRORS, INFECTIONS, ETC.) OCCUR?

OPTION 1.10.1: Providers should not be paid more for care needed to address preventable adverse events or the complications resulting from such events.

OPTION 1.10.2: Providers should be paid for care needed to address preventable adverse events, but payment bonuses or penalties should be provided based on the rates of preventable adverse events.

ISSUE 1.11: SHOULD FINANCIAL INCENTIVES BEYOND THE BASIC PAYMENT LEVEL BE PROVIDED FOR DIFFERENCES IN PERFORMANCE?

OPTION 1.11.1: Specific financial incentives should not be provided to providers; instead, comparative information for payers and patients on performance levels and prices should be used to drive improvements in performance.

OPTION 1.11.2: Specific financial incentives should be provided for those aspects of care for which the payment system provides inadequate incentives or undesirable disincentives.

Section II-B discusses the areas where incentives may be needed. The detailed issues and options for how to implement specific financial incentive programs are discussed in Section VII.

ISSUE 1.12: HOW SHOULD PATIENTS BE ENCOURAGED TO CHOOSE HIGH QUALITY/LOW-COST PROVIDERS?

OPTION 1.12.1: Patients should be given complete discretion to choose providers, using available information on quality and cost of providers as they wish.

OPTION 1.12.2: Patients should be given financial incentives by payers (e.g., lower copays or co-insurance amounts) for using providers with higher quality and/or lower cost.

OPTION 1.12.3: Patients should be given financial disincentives by payers (e.g., higher copays or co-insurance amounts) for using providers with lower quality and/or higher cost.

OPTION 1.12.4: Payers should refuse to pay for care by the lowest quality and highest cost providers, unless the care is provided in emergency circumstances.

See Section VIII for issues regarding the development and dissemination of quality and cost information.

ISSUE 1.13: HOW SHOULD PATIENTS BE ENCOURAGED OR ASSISTED TO ADHERE TO CARE PROCESSES THAT AFFECT OUTCOMES OR COSTS?

Patient preferences and patient adherence as well as provider preferences and performance can have a significant impact on outcomes and costs. For example, research has indicated that a major cause of patients being readmitted to the hospital after discharge for treatment of a major acute episode, is failure to comply with post-discharge instructions. This may be due to poorly explained or unrealistic expectations by the hospital or the patient's physician(s), but it can also be due to patient factors outside of the control of the hospital and physicians.

OPTION 1.13.1: Payers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes recommended or required by their health care provider.

OPTION 1.13.2: Payers should provide financial incentives to providers based on the level of patient involvement in care planning and/or patient adherence with care processes.

OPTION 1.13.3: Providers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes recommended or required by the provider.

OPTION 1.13.4: Providers should establish proactive systems for educating, monitoring, and encouraging patient adherence, but no explicit financial incentives should be provided to patients.

Combinations of these options can also be considered.

2. Example of a Possible Payment System for Care of Major Acute Episodes

The following is just one *example* of how the options from the issues described above could be combined into a new method of payment for care of major acute episodes.

Method of Payment

- A single prospectively defined Episode of Care Payment (ECP) would be made to cover all of a provider's services associated with an episode of care for a patient, with the amount adjusted for the severity/risk of the patient. All providers (hospitals, physicians, home health care agencies, etc.) and all costs (e.g., drugs and medical devices) involved in the episode of care would be paid from this single payment.

Defining a Recommended Base Payment Amount

- A recommended Episode of Care Payment (ECP) amount would be established by a regional public/private collaborative (involving both payers and providers) for each combination of a diagnosis and patient severity level.
- The recommended ECP amount would be based on the estimated cost of delivering all elements of the Clinical Practice Guideline (where one exists) for that diagnosis/severity level, plus a "warranty factor" to cover adverse events. The warranty factor would be computed as the current lowest rate of adverse events for that diagnosis/severity combination among providers times the estimated average cost of treating the adverse events.
- The ECP would include the estimated costs of services by all providers involved in the episode of care, along with a standard allocation of the payment to individual providers based on the proportion of the overall cost attributable to each provider.

Defining the Actual Base Payment Amount

- Providers or groups of providers would define and announce their actual ECP or portion of an ECP (i.e., their "price") for a particular diagnosis/severity combination as a percentage of the suggested ECP. Providers could charge different amounts to different payers, including individuals self-paying for care.
- Groups of providers could agree to share the ECP in any way they wished, either based on the standard allocation or a different allocation (e.g., based on cost savings achieved beyond the estimated costs of care). In the absence of such an agreement, the payer would pay each provider their standard allocation of the ECP times the provider's percentage discount/premium.

Conditions for Receiving the Base Payment Amount

- Patients would be entered into a regional registry so that outcomes could be tracked for purposes of measuring performance.
- Retroactive adjustments to payments would be made for cases where all mandatory care elements of the Clinical Practice Guideline for patients of that

diagnosis/severity had not been provided, unless certification were given by an appropriate physician that the excluded elements of care were contraindicated in that patient's case or that the patient was participating in a clinical trial.

- Providers would not be paid for additional episodes of care nor otherwise be paid additionally for care needed to address preventable adverse events or the complications resulting from such events.
- Providers would be required to accept all patients in a particular diagnosis/severity combination from a particular payer in order to accept any patients of that type.

Adjustments to the Base Payment Amount

- The recommended ECP amount would be adjusted periodically in response to updates in Clinical Practice Guidelines, the discounts offered by providers, new technologies, inflation, etc.
- Providers would be permitted to revise their actual ECP rates upward at most yearly, but would be encouraged to revise them downward whenever possible.
- No adjustment in payment would be made for patients requiring significantly more services or costs than were assumed in computing the base payment level, but the outlier cases would be documented and used to adjust the diagnosis and severity categories and/or future base payment levels in the next year.
- Payers in a region would contribute funding to a pool on a formula basis for the purpose of making additional payments to teaching hospitals to cover the additional costs of medical education.

Performance Measurement and Incentives

- The providers of services under the ECP would report publicly on the outcomes they achieve for patients paid for under that ECP and on their level of compliance with non-mandatory processes under the Clinical Practice Guideline.

Encouraging Patients to Promote Quality and Cost Containment

- Payers would refuse to pay for care at the lowest-quality, highest cost providers except under emergency circumstances. Patients choosing to use those providers, except in an emergency, would be liable to pay the full costs of care.
- Patients using the highest-quality, lowest-cost providers would have a significantly reduced copayment amount and/or receive financial rebates.
- Patients would receive financial rebates from the payer for compliance with care processes recommended by the provider.

B. Creating a Value-Based Payment System for Care of Chronic Conditions

This section focuses on how payers should pay for *care of chronic conditions*, i.e., conditions such as diabetes, hypertension, heart failure, asthma, etc. (see Section II-C).

There is growing agreement that people with chronic conditions require a different type of care than is typically associated with the major acute episode discussed in Subsection VI-A. However, even within the broad category of chronic conditions, there are very different categories of patients requiring different types of care (see Section II-C). How care of this broad range of patients should be paid for is the subject of this subsection.

This section is divided into nine different issues in five categories that need to be addressed in order to achieve the goals proposed in the previous section:

Basic Payment Method

2.1 What basic payment method should be used to pay providers for care of chronic conditions?

Bundling of Payment

2.2 Should payments to medical care managers and other providers providing care related to chronic conditions be bundled together into a single payment to one accountable provider?

Payment Levels

2.3 If a Fee for Service payment system is used, how should the fee levels be determined?

2.4 If a Care Management Payment (CMP) system is used, how should the base payment level be determined?

2.5 Should payment levels be adjusted for "outlier" cases?

Performance Standards

2.6 What level of service or performance should be required in order to receive the base payment level?

2.7 Should financial incentives beyond the basic payment level be provided for differences in performance?

Patient Incentives

2.8 How should patients be encouraged to choose high quality/low-cost providers?

2.9 How should patients be encouraged or assisted to adhere to care processes that affect outcomes or costs?

Ways that the payments defined in this section might be modified at the margin to reward or penalize varying levels of performance will be discussed separately, in Section VII.

For each issue, options for resolution are suggested. In most cases, there are many potential options for addressing an issue – an attempt has been made to identify options that differ along major conceptual dimensions, but the specifics of individual options will likely need to be modified or enhanced in order to insure that specific goals and concerns are addressed. In addition, options for a particular issue may not be mutually exclusive.

1. Key Issues and Options

ISSUE 2.1: WHAT BASIC PAYMENT METHOD SHOULD BE USED FOR CARE OF CHRONIC CONDITIONS?

OPTION 2.1.1: For care of chronic conditions, the patient's primary care physician should be paid on a fee-for-service basis. Fees for care management services should (1) be sufficient to cover time spent counseling patients and conducting compliance monitoring/encouragement, (2) not be restricted to services provided by a physician in a face-to-face visit, and (3) allow multiple services to be provided on the same day/in the same visit. Other providers should also be paid on a fee-for-service basis, except for major acute episodes associated with the chronic condition, which would be paid as specified in Section VI-A.

OPTION 2.1.2: For care of chronic conditions, a medical care manager should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care management services associated with that chronic condition, with the amount adjusted for the severity/risk of the patient. The medical care manager or other providers should be paid separately for preventive care and care of minor acute episodes provided beyond basic care management. Major acute episodes and long-term care associated with the chronic condition would be paid separately.

The medical care manager could be a physician or a practice staffed by a team of health care professionals.

The American College of Physicians (ACP) has proposed an "advanced medical home" model, in which patients have a personal physician working with a team of healthcare professionals. According to ACP, for most patients the personal physician would most appropriately be a primary care physician, but it could be a specialist or subspecialist for patients requiring on-going care for certain conditions, e.g., severe asthma, complex diabetes, complicated cardiovascular disease, rheumatologic disorders, and malignancies. In the ACP model, rather than being a "gatekeeper" who restricts patient access to services, the personal physician would coordinate and facilitate the patient's care by using evidence-based medicine and clinical decision support tools, by creating an integrated, coherent plan for ongoing medical care in partnership with the patient and their families, by providing enhanced and convenient access to care not only through face-to-face visits but also via telephone, email, and other modes of communication, by identifying and measuring key quality indicators to demonstrate continuous improvement in health status indicators for individuals and populations treated, and by adopting and implementing the use of health information technology to promote quality of care, to establish a safe environment in which to receive care, to protect the security of health information, and to promote the provision of health information exchange.

OPTION 2.1.3: For care of chronic conditions, a medical care manager should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care management, preventive care, and minor acute care services associated with that chronic condition, with the amount adjusted for the severity/risk of the patient. Major acute episodes and long-term care associated with the chronic condition would be paid separately.

OPTION 2.1.4: For care of chronic conditions, a medical care manager should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care associated with that chronic condition, including preventive care, minor acute care, and any major acute episodes, with the amount adjusted for the severity/risk of the patient. Long-term care associated with the chronic condition would be paid separately.

OPTION 2.1.5: For care of chronic conditions, a medical care manager should be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care associated with that chronic condition, including preventive care, minor acute care, any major acute episodes, and any long-term care services (e.g., nursing home or home health care), with the amount adjusted for the severity/risk of the patient.

ISSUE 2.2: SHOULD PAYMENTS TO MEDICAL CARE MANAGERS AND OTHER PROVIDERS PROVIDING CARE RELATED TO CHRONIC CONDITIONS BE BUNDLED TOGETHER INTO A SINGLE PAYMENT TO ONE ACCOUNTABLE PROVIDER?

Currently, most payment systems are designed to pay each provider separately for the services they provide. A "bundled" payment means that a single payment is defined to cover the services of two or more providers.

OPTION 2.2.1: For care of chronic conditions, separate payments should be defined and made to the medical care manager and any other providers involved in providing the types of care defined in Issue 2.1.

OPTION 2.2.2: For care of chronic conditions, a single payment should be defined and paid to the medical care manager for the services of all physicians, medical practices, and diagnostic services involved in providing the types of care defined in Issue 2.1.

OPTION 2.2.3: For care of chronic conditions, a single payment should be defined and paid to the medical care manager for the services of all other providers involved in providing the types of care defined in Issue 2.1.

For example, under Option 2.2.2, the medical care manager could be paid a single payment to cover the costs of both services provided directly by the medical care manager and by diagnostic laboratories, etc. Under Option 2.2.3, for a patient requiring long-term care services (whether in a nursing home or in a community setting with home health care), a single payment would be defined to cover the costs of physician care, long-term care, and any hospitalizations.

ISSUE 2.3: IF A FEE-FOR-SERVICE SYSTEM IS USED, HOW SHOULD THE FEE LEVELS BE DETERMINED?

OPTION 2.3.1: Fee levels should be based on the current Resource-Based Relative Value Scale (RBRVS) used by Medicare, but the relative values for care

management services should be increased significantly to reflect the need for more intensive patient management services for persons with chronic conditions.

OPTION 2.3.2: A national, state, or regional public-private collaborative (with representation from both payers and providers) should determine proposed fee levels for care management services. Fee levels for other services should be based on the current Resource-Based Relative Value Scale (RBRVS) used by Medicare. Individual providers could propose fee levels above or below the proposed level.

ISSUE 2.4: IF A CARE MANAGEMENT PAYMENT (CMP) SYSTEM IS USED, HOW SHOULD THE BASE PAYMENT LEVEL BE DETERMINED?

OPTION 2.4.1: For each combination of diagnosis and patient severity for which a separate Care Management Payment will be made, providers should propose the amount of payment (i.e. their "price" for the management of care).

OPTION 2.4.2: For each combination of diagnosis and patient severity for which a separate Care Management Payment (CMP) will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should define a recommended set of best-practice services to be covered by the CMP and, where data are available, estimate the current cost for that set of services. Actual CMP levels would be determined through negotiations between providers and payers.

OPTION 2.4.3: For each combination of diagnosis and patient severity for which a separate Care Management Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a recommended payment level based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity (i.e., a "suggested price" for the management of care). Providers should either accept the recommended payment level, or propose a discount below (or premium above) the payment level that they will accept (i.e., their "price" for the management of care) for patients in that category.

For example, Allan Goroll and colleagues have proposed calculating a payment level for primary care providers based on a budget reasonably expected to cover the personnel and operating expenses for a primary care practice, divided by the number of patients of a particular need/risk level the practice could be expected to manage. (See "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," by Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, and Laurence B. Gardner, *Journal of General Internal Medicine*, 2007.)

Options 2.4.1, 2.4.2, and 2.4.3 are each consistent with either a bidding model or a negotiation model of pricing – in each case, the provider proposes a price and the payer would either accept or reject the price. Options 2.4.2 and 2.4.3 would introduce a "starting point" for bidding or negotiations through the recommended payment level.

OPTION 2.4.4: For each combination of diagnosis and patient severity for which a separate Care Management Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a payment level based on a study to estimate the cost of delivering good quality care for that combination

of diagnosis and severity. Providers should accept the payment level as payment in full for the care provided to patients in that category.

Establishing a uniform payment level across all providers and payers will likely raise anti-trust concerns. A special ruling from the U.S. Attorney General and state Attorney(s) General, or legislation, may be needed to provide a safe harbor for such a pricing approach if appropriate benefits can be demonstrated.

ISSUE 2.5: SHOULD PAYMENT LEVELS BE ADJUSTED FOR "OUTLIER" CASES?

"Outlier" cases are patients for whom the level of services or costs associated with quality care are significantly higher than for other patients with the same diagnosis and ostensibly the same severity level. Fee-for-service and per diem payments inherently compensate providers more for this additional care, but a Care Management Payment system would not, without explicit provisions to do so.

OPTION 2.5.1: When a provider documents that its total cost of caring for a patient exceeds a certain multiple of the base payment level for that category of patient (based on diagnosis and severity), the provider should receive an additional payment to cover a portion of those costs.

OPTION 2.5.2: When a provider documents that it was required to provide services significantly beyond the level assumed in computing the base payment level, the provider should receive an additional payment to cover a portion of the documented out-of-pocket costs associated with the additional care.

The distinction between Option 2.5.1 and Option 2.5.2 is that in the latter, the provider documents *services* performed beyond the normally expected level of services, whereas in the former, the provider documents *costs* beyond the normally expected level of costs. Also, in the latter, the outlier payment is based on out-of-pocket costs (e.g., medications, etc.) rather than total costs (e.g., allocations of overhead, salaries, etc.).

OPTION 2.5.3: No adjustment in payment should be made for patients requiring significantly more services than were assumed in computing the base payment level, but such outlier cases should be documented and used by the payer and provider to adjust the diagnosis/severity categories (e.g., by adding a new severity level) and/or to adjust future base payment levels.

Failure to provide any adjustment could violate Goal 4, by encouraging providers to avoid patients with unusually high care needs that are not effectively captured in the severity adjustment system.

ISSUE 2.6: WHAT LEVEL OF SERVICE OR PERFORMANCE SHOULD BE REQUIRED IN ORDER TO RECEIVE THE BASE PAYMENT LEVEL?

Because of concerns that many patients are not receiving elements of care that have been determined to be appropriate or necessary, most current pay-for-performance systems have an explicit or implicit goal of *encouraging*, but not *mandating*, that providers reach 100% compliance with certain processes that have been demonstrated to improve patient outcomes. However, an alternative approach would be to define processes where 100% compliance is considered essential (except where they are clearly contraindicated or where the patient is participating in a

clinical trial explicitly to test new processes) and to *require* that those processes be performed in order to receive payment.

OPTION 2.6.1: Payers and/or a public-private collaborative (involving both payers and providers) should define those structures for care management that are considered mandatory for patients in a particular age/severity category in order for a provider to receive CMP payments.

For example, providers might be required to have data systems and staffing levels adequate to support regular monitoring and follow-up of patients with chronic conditions.

OPTION 2.6.2: Payers and/or a public-private collaborative (involving both payers and providers) should define those processes that are considered mandatory for patients in a particular age/severity category (either as part of an existing Clinical Practice Guideline, where one exists, or separately), and providers should only be paid if those processes are delivered, unless there is clear documentation that the processes are contra-indicated for the patient or if the patient is participating in a formal clinical trial of alternative processes.

OPTION 2.6.3: No mandatory processes should be established in order for providers to receive payment.

ISSUE 2.7: SHOULD FINANCIAL INCENTIVES BEYOND THE BASIC PAYMENT LEVEL BE PROVIDED FOR DIFFERENCES IN PERFORMANCE?

OPTION 2.7.1: Specific financial incentives should not be provided to providers; instead, comparative information for payers and patients on performance levels and prices should be used to drive improvements in performance.

OPTION 2.7.2: Specific financial incentives should be provided for those aspects of care for which the payment system provides inadequate incentives or undesirable disincentives.

Section II-B discusses the areas where incentives may be needed. The detailed issues and options for how to implement specific financial incentive programs are discussed in Section VII.

ISSUE 2.8: HOW SHOULD PATIENTS BE ENCOURAGED TO CHOOSE HIGH QUALITY/LOW-COST PROVIDERS?

OPTION 2.8.1: Patients should be given complete discretion to choose providers, using available information on quality and cost of providers as they wish.

OPTION 2.8.2: Patients should be given financial incentives by payers (e.g., lower copays or co-insurance amounts) for using providers with higher quality and/or lower cost.

OPTION 2.8.3: Patients should be given financial disincentives by payers (e.g., higher copays or co-insurance amounts) for using providers with lower quality and/or higher cost.

OPTION 2.8.4: Payers should refuse to pay for care by the lowest quality and highest cost providers.

ISSUE 2.9: HOW SHOULD PATIENTS BE ENCOURAGED OR ASSISTED TO ADHERE TO CARE PROCESSES THAT AFFECT OUTCOMES OR COSTS?

OPTION 2.9.1: Payers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes recommended or required by their health care provider.

OPTION 2.9.2: Payers should provide financial incentives to providers based on the level of patient involvement in care planning and/or patient adherence with care processes.

OPTION 2.9.3: Providers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes recommended or required by the provider.

OPTION 2.9.4: Providers should establish proactive systems for educating, monitoring, and encouraging patient engagement with treatment processes. Payers should then provide incentives to patients (financial and non-financial) for adherence with care processes co-developed by patients and providers.

OPTION 2.9.5: Providers should establish proactive systems for educating, monitoring, and encouraging patient adherence, but no explicit financial incentives should be provided to patients.

2. Example of a Possible Payment System for Care of Chronic Conditions

The following is just one *example* of how the options from the issues described above could be combined into a new method of payment for care of chronic conditions.

Method of Payment

- A single provider would be designated as the medical care manager for a patient with a chronic condition and be paid a single, periodic, prospectively defined Care Management Payment (CMP) to cover all of the care management, preventive care, and minor acute care services associated with that chronic condition, with the amount adjusted for the severity/risk of the patient. All providers and all costs associated with this care would be covered by the single payment. Major acute episodes and long-term care associated with the chronic condition would be paid separately.

Defining a Recommended Base Payment Amount

- A recommended Care Management Payment (CMP) amount would be established by a regional public/private collaborative (involving both payers and providers) for each combination of a diagnosis and patient severity level.
- The recommended CMP amount would be based on the estimated cost of delivering the care management, prevention, and minor acute care elements of the Clinical Practice Guidelines for that diagnosis/severity level (where one exists).
- The CMP would include the estimated costs of services by all providers involved in the episode of care.

Defining the Actual Base Payment Amount

- Providers or groups of providers would define and announce their actual CMP (i.e., their "price") for patients in each diagnosis/severity level as a percentage of the recommended CMP. Providers could charge different amounts to different payers, including individuals self-paying for care.
- Groups of providers could agree to share the CMP in any way they wished.

Conditions for Receiving the Base Payment Amount

- Patients would be entered into a regional registry so that outcomes could be tracked for purposes of measuring performance.
- The CMP would be made on a monthly basis to the provider serving as the patient's medical care manager in order to provide or coordinate the provision of all routine and preventive care associated with the diagnosed condition.
- Retroactive adjustments to payments would be made for cases where all mandatory care elements of the Clinical Practice Guideline for patients of that diagnosis/severity had not been provided, unless certification is given by an appropriate physician that the excluded elements of care were contraindicated in that patient's case or that the patient was participating in a clinical trial.

- Payment would not depend on which provider or health care professional provided the care (as long as the professional was licensed to do so), or when or where the care was provided (e.g., in one office visit, multiple office visits, in the home, etc.).

Adjustments to the Base Payment Amount

- The recommended CMP amount would be adjusted periodically in response to updates in Clinical Practice Guidelines, the discounts offered by providers, new technologies, inflation, etc.
- Providers would be permitted to revise their actual CMP rates upward at most yearly, but would be encouraged to revise them downward whenever possible.
- No adjustment in payment would be made for patients requiring significantly more services or costs than were assumed in computing the base payment level, but the outlier cases would be documented and used to adjust the diagnosis and severity categories and/or future base payment levels in the next year.

Performance Measurement and Incentives

- The medical care manager would report publicly and receive a bonus payment based on the level of outcomes for patients paid for under the CMP and/or the level of provider compliance with non-mandatory processes under the Clinical Practice Guideline. One of the outcomes would be the number and severity of major acute episodes for the patients being managed by the medical care manager.
- The amount of the bonus would be based on a portion of the present value of avoided costs associated with the improved outcomes or process compliance. (E.g., if the number of major acute episodes for patients declined, then the bonus payment would be based on a portion of the estimated cost of the avoided ECP payments.)

Encouraging Patients to Promote Quality and Cost Containment

- Patients using the highest-quality, lowest-cost providers would have a reduced copayment amount.
- Patients would also receive a financial reward based on adherence with both processes and outcomes (e.g., stopping smoking, getting immunizations, lowering cholesterol level) recommended by their medical care manager.

C. Creating a Value-Based Payment System for Care of Minor Acute Episodes

This section focuses on how payers should pay for *care of minor acute episodes*, i.e., minor wounds, normal childbirth, minor respiratory diseases, etc. (see Section II-C). Some conditions may be self-limiting or may not even require treatment, but some may be the early manifestation of something more serious or potentially more serious. This excludes exacerbations of a condition that result in a Major Acute Care episode, which are addressed in Section VI-A.

This section is divided into nine different issues in five categories that need to be addressed in order to achieve the goals proposed in Section V:

Basic Payment Method

3.1 What basic payment method should be used to pay providers for care of minor acute episodes?

Bundling of Payment

3.2 Should payments to all providers for minor acute episodes be bundled together into a single payment?

Payment Levels

3.3 If a fee-for-service payment or an episode of care payment is used, how should the base payment level be determined?

3.4 If a care management payment system is used, how should the base payment level be determined?

Performance Standards

3.5 What level of service or performance should be required in order to receive the base payment level?

3.6 How should payments be changed when preventable adverse events (errors, infections, etc.) occur?

3.7 Should financial incentives beyond the basic payment level be provided for differences in performance?

Patient Incentives

3.8 How should patients be encouraged to choose high quality/low-cost providers?

3.9 How should patients be encouraged or assisted to adhere to care processes that affect outcomes or costs?

Ways that the payments defined in this section might be modified at the margin to reward or penalize varying levels of performance will be discussed separately, in Section VII.

For each issue, options for resolution are suggested. In most cases, there are many potential options for addressing an issue – an attempt has been made to identify options that differ along major conceptual dimensions, but the specifics of individual options will likely need to be modified or enhanced in order to insure that specific goals and concerns are addressed. In addition, options for a particular issue may not be mutually exclusive.

1. Key Issues and Options

ISSUE 3.1: WHAT BASIC PAYMENT METHOD SHOULD BE USED FOR CARE OF MINOR ACUTE EPISODES?

OPTION 3.1.1: For care of minor acute episodes, any licensed provider should be paid on a fee-for-service basis to provide care for the condition.

OPTION 3.1.2: For minor acute episodes, a single prospectively defined Episode of Care Payment (ECP) should be made to cover all of a provider's services associated with that episode of care, with the amount adjusted for the severity/risk of the patient where there is likely to be a significant difference in cost.

OPTION 3.1.3: A single prospectively defined Care Management Payment (CMP) should be paid to a primary care provider to cover all minor acute care provided to all of the patients cared for by that provider, with the amount adjusted for the severity/risk of the patients cared for by that provider.

ISSUE 3.2: SHOULD PAYMENTS TO ALL PROVIDERS FOR MINOR ACUTE EPISODES BE BUNDLED TOGETHER INTO A SINGLE PAYMENT?

Currently, most payment systems are designed to pay each provider separately for the services they provide. A "bundled" payment means that a single payment is defined to cover the services of two or more providers, with a goal of aligning incentives for all of the providers.

OPTION 3.2.1: For minor acute episodes, separate payments should be defined and made to different providers involved with the care.

OPTION 3.2.2: For minor acute episodes, a single payment should be defined and paid to a primary care provider to cover the costs of all of the physicians, physician practices, and diagnostic services associated with the episode of care.

OPTION 3.2.3: For minor acute episodes, a single payment should be defined and paid to a primary care provider to cover the costs of all providers associated with the episode of care.

ISSUE 3.3: IF A FEE-FOR-SERVICE PAYMENT OR AN EPISODE OF CARE PAYMENT IS USED, HOW SHOULD THE BASE PAYMENT LEVEL BE DETERMINED?

OPTION 3.3.1: For each service for which a separate fee will be paid, or for each combination of diagnosis and patient severity for which a separate Episode of Care Payment will be made, providers should propose the amount of payment (i.e. their "price" for the service or episode of care).

OPTION 3.3.2: For each service for which a separate fee will be paid, or for each combination of diagnosis and patient severity for which a separate Episode of Care Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a recommended payment level based on a study to estimate the cost of delivering good quality care for that service or for that category of diagnosis and severity (i.e., a "suggested price" for the service or episode of care). Providers would either accept the recommended payment level, or propose a discount below (or premium above) the payment level that they will accept (i.e., their "price" for the service or episode of care) for that category of patient. Proposed base payment levels should differ from region to region based on the differences in cost-of-living by region, but detailed cost differences should be captured by providers in their discounts/premiums over the standard payment rate.

Options 3.3.1 and 3.3.2 are both consistent with either a bidding model or a negotiation model of pricing – in each case, the provider proposes a price and the payer would either accept or reject the price. Option 3.3.2 would introduce a "starting point" for bidding or negotiations through the recommended payment level.

OPTION 3.3.3: For each service for which a separate fee will be paid, or for each combination of diagnosis and patient severity for which a separate Episode of Care Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a payment level based on a study to estimate the cost of delivering good quality care for that service or for that combination of diagnosis and severity. Base payment levels should differ from region to region based on the differences in cost-of-living by region. Providers should accept the payment level as payment in full for the care provided to patients in that category.

Establishing a uniform payment level across all providers and payers in a region will likely raise anti-trust concerns. A special ruling from the U.S. Attorney General and state Attorney(s) General, or legislation, may be needed to provide a safe harbor for such a pricing approach if appropriate benefits can be demonstrated.

ISSUE 3.4: IF A CARE MANAGEMENT PAYMENT SYSTEM IS USED, HOW SHOULD THE BASE PAYMENT LEVEL BE DETERMINED?

OPTION 3.4.1: For any particular mix of severity/risk for the patient population being served, providers should propose the amount of payment (i.e., their "price" for the management of care).

OPTION 3.4.2: For any particular mix of severity/risk for the patient population being served, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a

recommended payment level based on a study to estimate the cost of delivering good quality care for that category of diagnosis and severity (i.e., a "suggested price" for the management of care). Providers should either accept the recommended payment level, or propose a discount below (or premium above) the payment level that they will accept (i.e., their "price" for the management of care) for patients in that category.

OPTION 3.4.3: For any particular mix of severity/risk for the patient population being served, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a payment level based on a study to estimate the cost of delivering good quality care for that combination of diagnosis and severity. Providers should accept the payment level as payment in full for the care provided to patients in that category.

As with the previous issue, establishing a uniform payment level across all providers and payers in a region will likely raise anti-trust concerns. A special ruling from the U.S. Attorney General and state Attorney(s) General, or legislation, may be needed to provide a safe harbor for such a pricing approach if appropriate benefits can be demonstrated.

ISSUE 3.5: WHAT LEVEL OF SERVICE OR PERFORMANCE SHOULD BE REQUIRED IN ORDER TO RECEIVE THE BASE PAYMENT LEVEL?

Because of concerns that many patients are not receiving elements of care that have been determined to be appropriate or necessary, most current pay-for-performance systems have an explicit or implicit goal of *encouraging*, but not *mandating*, that providers reach 100% compliance with certain processes that have been demonstrated to improve patient outcomes. However, an alternative approach would be to define processes where 100% compliance is considered essential (except where they are clearly contraindicated or where the patient is participating in a clinical trial explicitly to test new processes) and to *require* that those processes be performed in order to receive payment.

OPTION 3.5.1: Payers and/or a public-private collaborative (involving both payers and providers) should define those processes that are considered mandatory for patients in a particular diagnosis/severity category, and providers should only be paid if those processes are delivered, unless there is clear documentation that the processes are contra-indicated for the patient or if the patient is participating in a formal clinical trial of alternative processes.

OPTION 3.5.2: No mandatory processes should be established in order for providers to receive payment.

ISSUE 3.6: HOW SHOULD PAYMENTS BE CHANGED WHEN PREVENTABLE ADVERSE EVENTS (ERRORS, INFECTIONS, ETC.) OCCUR?

OPTION 3.6.1: Providers should not be paid more for care needed to address preventable adverse events or the complications resulting from such events.

OPTION 3.6.2: Providers should be paid for care needed to address preventable adverse events, but payment bonuses or penalties should be provided based on the rates of preventable adverse events.

ISSUE 3.7: SHOULD FINANCIAL INCENTIVES BEYOND THE BASIC PAYMENT LEVEL BE PROVIDED FOR DIFFERENCES IN PERFORMANCE?

OPTION 3.7.1: Specific financial incentives should not be provided to providers; instead, comparative information for payers and patients on performance levels and prices should be used to drive improvements in performance.

OPTION 3.7.2: Specific financial incentives should be provided for those aspects of care for which the payment system provides inadequate incentives or undesirable disincentives.

Section II-B discusses the areas where incentives may be needed. The detailed issues and options for how to implement specific financial incentive programs are discussed in Section VII.

ISSUE 3.8: HOW SHOULD PATIENTS BE ENCOURAGED TO CHOOSE HIGH QUALITY/LOW-COST PROVIDERS?

OPTION 3.8.1: Patients should be given complete discretion to choose providers, using available information on quality and cost of providers as they wish.

OPTION 3.8.2: Patients should be given financial incentives by payers (e.g., lower copays or co-insurance amounts) for using providers with higher quality and/or lower cost.

OPTION 3.8.3: Patients should be given financial disincentives by payers (e.g., higher copays or co-insurance amounts) for using providers with lower quality and/or higher cost.

OPTION 3.8.4: Payers should refuse to pay for care by the lowest quality and highest cost providers.

ISSUE 3.9: HOW SHOULD PATIENTS BE ENCOURAGED OR ASSISTED TO ADHERE TO CARE PROCESSES THAT AFFECT OUTCOMES OR COSTS?

OPTION 3.9.1: Payers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes required or recommended by their health care provider.

OPTION 3.9.2: Payers should provide financial incentives to providers based on the level of patient involvement in care planning and/or patient adherence with care processes.

OPTION 3.9.3: Providers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes required or recommended by the provider.

OPTION 3.9.4: Providers should establish proactive systems for educating, monitoring, and encouraging patient adherence, but no explicit financial incentives should be provided to patients.

2. Example of a Possible Payment System for Care of Minor Acute Episodes

The following is just one *example* of how the options from the issues described above could be combined into a new method of payment for care of minor acute episodes.

Method of Payment

- A single prospectively defined Episode of Care Payment (ECP) would be made to cover all of a provider's services associated with an episode of care for minor acute episodes, with the amount adjusted for the severity/risk of the patient where there is likely to be a significant difference in cost. All providers (hospitals, physicians, home health care agencies, etc.) and all costs (e.g., drugs and medical devices) involved in the episode of care would be paid from this single payment.

Defining a Recommended Base Payment Amount

- For those minor acute episodes for which a Clinical Practice Guideline has been established, a recommended Episode of Care Payment (ECP) amount would be established by a regional public/private collaborative (involving both payers and providers) for each combination of a diagnosis and patient severity level.
- The recommended ECP amount would be based on the estimated cost of delivering all elements of the Clinical Practice Guideline for that diagnosis/severity level, plus a "warranty factor" to cover adverse events. The warranty factor would be computed as the current lowest rate of adverse events for that diagnosis/severity combination times the estimated average cost of treating the adverse events.
- The ECP would include the estimated costs of services by all providers involved in the episode of care, along with a standard allocation of the payment to individual providers based on the proportion of the overall cost attributable to each provider.

Defining the Actual Base Payment Amount

- Providers or groups of providers would define and announce their actual ECP or portion of an ECP (i.e., their "price") for a particular diagnosis/severity combination as a percentage of the suggested ECP. Providers could charge different amounts to different payers, including individuals self-paying for care.
- Where no suggested Episode of Care Payment had been established, providers would propose fee levels for their services.
- Groups of providers could agree to share the ECP in any way they wished, either based on the standard allocation or a different allocation (e.g., based on cost savings achieved beyond the estimated costs of care). In the absence of such an agreement, the payer would pay each provider their standard allocation of the ECP times the provider's percentage discount/premium.

Conditions for Receiving the Base Payment Amount

- Patients would be entered into a regional registry so that outcomes could be tracked for purposes of measuring performance.
- Retroactive adjustments to payments would be made for cases where all mandatory care elements of the Clinical Practice Guideline for patients of that diagnosis/severity had not been provided, unless certification were given by an appropriate physician that the excluded elements of care were contraindicated in that patient's case or that the patient was participating in a clinical trial.
- Providers would not be paid for additional episodes of care nor otherwise be paid additionally for care needed to address preventable adverse events or the complications resulting from such events.

Adjustments to the Base Payment Amount

- The recommended ECP amount would be adjusted periodically in response to updates in Clinical Practice Guidelines, the discounts offered by providers, new technologies, inflation, etc.
- Providers would be permitted to revise their actual ECP rates upward at most yearly, but would be encouraged to revise them downward whenever possible.
- No adjustment in payment would be made for patients requiring significantly more services or costs than were assumed in computing the base payment level, but the outlier cases would be documented and used to adjust the diagnosis and severity categories and/or future base payment levels in the next year.

Performance Measurement and Incentives

- The providers of services under the ECP would report publicly on the outcomes they achieve for patients paid for under that ECP and on their level of compliance with non-mandatory processes under the Clinical Practice Guideline.

Encouraging Patients to Promote Quality and Cost Containment

- Payers would refuse to pay for care at the lowest-quality, highest cost providers except under emergency circumstances. Patients choosing to use those providers, except in an emergency, would be liable to pay the full costs of care.
- Patients using the highest-quality, lowest-cost providers would have a significantly reduced copayment amount and/or receive financial rebates.
- Patients would receive financial rebates from the payer for compliance with care processes recommended by the provider.

D. Creating a Value-Based Payment System for Preventive Care

This section focuses on how payers should pay for *preventive care*, i.e., immunizations, screening tests, counseling, etc. designed to prevent chronic conditions and some acute episodes (see Section II-C).

This section is divided into seven different issues in five categories that need to be addressed in order to achieve the goals proposed in the previous section:

Basic Payment Method

4.1 What basic payment method should be used to pay providers for preventive care?

Bundling of Payment

4.2 Should payments to all providers for preventive care be bundled together into a single payment?

Payment Levels

4.3 How should the base payment level for a Preventive Care Management Payment be determined?

Performance Standards

4.4 What level of service or performance should be required in order to receive the base payment level?

4.5 Should financial incentives beyond the basic payment level be provided for differences in performance?

Patient Incentives

4.6 How should patients be encouraged to choose high quality/low-cost providers?

4.7 How should patients be encouraged or assisted to adhere to care processes that affect outcomes or costs?

Ways that the payments defined in this section might be modified at the margin to reward or penalize varying levels of performance will be discussed separately, in Section VII.

For each issue, options for resolution are suggested. In most cases, there are many potential options for addressing an issue – an attempt has been made to identify options that differ along major conceptual dimensions, but the specifics of individual options will likely need to be modified or enhanced in order to insure that specific goals and concerns are addressed. In addition, options for a particular issue may not be mutually exclusive.

1. Key Issues and Options

ISSUE 4.1: WHAT BASIC PAYMENT METHOD SHOULD BE USED FOR PREVENTIVE CARE?

OPTION 4.1.1: For preventive care, any licensed provider should be paid on a fee-for-service basis for preventive care services. Fees should (1) be sufficient to cover time spent counseling patients and conducting compliance monitoring/encouragement, (2) not be restricted to services provided by a physician in a face-to-face visit, and (3) allow multiple services to be provided on the same day/in the same visit.

OPTION 4.1.2: For preventive care, a preventive care manager should be paid a periodic, prospectively defined Preventive Care Management Payment (CMP) to cover a full range of preventive care services for an individual patient, with the amount adjusted for the age/risk of the patient. In addition, the medical care manager should be paid on a fee-for-service basis for actual preventive services provided beyond basic care management (e.g., immunizations). These payments would not be expected to cover either minor or major acute episodes, or prevention associated with management of a chronic condition, which would be covered under other payment systems.

OPTION 4.1.3: For preventive care, a preventive care manager should be paid a periodic, prospectively defined Preventive Care Management Payment (CMP) to cover a full range of preventive care services for an individual patient, with the amount adjusted for the age/risk of the patient. This payment would also be expected to cover all minor acute episodes, but not major acute episodes or services associated with management of a chronic condition, which would be covered under other payment systems.

OPTION 4.1.4: For preventive care, a preventive care manager should be paid a periodic, prospectively defined Preventive Care Management Payment (CMP) to cover a specific set of preventive care services for a group of individuals, with the amount adjusted for the characteristics of the group. The group of individuals might be defined geographically (e.g., a particular neighborhood or residential building) or by demographic group (e.g., senior citizens or teenagers).

ISSUE 4.2: SHOULD PAYMENTS TO ALL PROVIDERS FOR PREVENTIVE CARE BE BUNDLED TOGETHER INTO A SINGLE PAYMENT?

Currently, most payment systems are designed to pay each provider separately for the services they provide. A "bundled" payment means that a single payment is defined to cover the services of two or more providers, with a goal of aligning incentives for all of the providers.

OPTION 4.2.1: For preventive care, separate payments should be defined and made to different providers involved with the care.

OPTION 4.2.2: For preventive care, a single payment should be defined and paid to an accountable primary care provider to cover the costs of all of the providers involved with the preventive care.

ISSUE 4.3: HOW SHOULD THE BASE PAYMENT LEVEL FOR A PREVENTIVE CARE MANAGEMENT PAYMENT (CMP) BE DETERMINED?

OPTION 4.3.1: For each combination of patient age/risk for which a separate Preventive Care Management Payment will be made, providers should propose the amount of payment (i.e., their "price" for the management of care).

OPTION 4.3.2: For each combination of patient age/risk for which a separate Preventive Care Management Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a recommended payment level based on a study to estimate the cost of delivering good quality care for that type of patient (i.e., a "suggested price" for the management of care). Providers should either accept the recommended payment level, or propose a discount below (or premium above) the payment level that they will accept (i.e., their "price" for the management of care) for patients in that category.

For example, Allan Goroll and colleagues have proposed calculating a payment level for primary care providers based on a budget reasonably expected to cover the personnel and operating expenses for a primary care practice, divided by the number of patients of a particular need/risk level the practice could be expected to manage. (See "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," by Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, and Laurence B. Gardner, *Journal of General Internal Medicine*, 2007.)

Options 4.3.1 and 4.3.2 are both consistent with either a bidding model or a negotiation model of pricing – in each case, the provider proposes a price and the payer would either accept or reject the price. Option 4.3.2 would introduce a "starting point" for bidding or negotiations through the recommended payment level.

OPTION 4.3.3: For each combination of patient age/risk for which a separate Preventive Care Management Payment will be made, a national, state, or regional public-private collaborative (with representation from both payers and providers) should determine a payment level based on a study to estimate the cost of delivering good quality care for that combination of diagnosis and severity. Providers should accept the payment level as payment in full for the care provided to patients in that category.

Establishing a uniform payment level across all providers and payers in a region will likely raise anti-trust concerns. A special ruling from the U.S. Attorney General and state Attorney(s) General, or legislation, may be needed to provide a safe harbor for such a pricing approach if appropriate benefits can be demonstrated.

ISSUE 4.4: WHAT LEVEL OF SERVICE OR PERFORMANCE SHOULD BE REQUIRED IN ORDER TO RECEIVE THE BASE PAYMENT LEVEL?

Because of concerns that many patients are not receiving elements of care that have been determined to be appropriate or necessary, most current pay-for-performance systems have an explicit or implicit goal of *encouraging*, but not *mandating*, that providers reach 100% compliance with certain processes that have been demonstrated to improve patient outcomes. However, an alternative approach would be to define processes where 100% compliance is considered essential (except where they are clearly contraindicated or where the patient is participating in a

clinical trial explicitly to test new processes) and to *require* that those processes be performed in order to receive payment.

OPTION 4.4.1: Payers and/or a public-private collaborative (involving both payers and providers) should define those prevention processes that are considered mandatory for patients in a particular age/severity category, and providers should only be paid if those processes are delivered, unless there is clear documentation that the processes are contra-indicated for the patient or if the patient is participating in a formal clinical trial of alternative processes.

OPTION 4.4.2: No mandatory processes should be established in order for providers to receive payment.

ISSUE 4.5: SHOULD FINANCIAL INCENTIVES BEYOND THE BASIC PAYMENT LEVEL BE PROVIDED FOR DIFFERENCES IN PERFORMANCE?

OPTION 4.5.1: Specific financial incentives should not be provided to providers; instead, comparative information for payers and patients on performance levels and prices should be used to drive improvements in performance.

OPTION 4.5.2: Specific financial incentives should be provided for those aspects of care for which the payment system provides inadequate incentives or undesirable disincentives.

Section II-B discusses the areas where incentives may be needed. The detailed issues and options for how to implement specific financial incentive programs are discussed in Section VII.

ISSUE 4.6: HOW SHOULD PATIENTS BE ENCOURAGED TO CHOOSE HIGH QUALITY/LOW-COST PROVIDERS?

OPTION 4.6.1: Patients should be given complete discretion to choose providers, using available information on quality and cost of providers as they wish.

OPTION 4.6.2: Patients should be given financial incentives by payers (e.g., lower copays or co-insurance amounts) for using providers with higher quality and/or lower cost.

OPTION 4.6.3: Patients should be given financial disincentives by payers (e.g., higher copays or co-insurance amounts) for using providers with lower quality and/or higher cost.

OPTION 4.6.4: Payers should refuse to pay for care by the lowest quality and highest cost providers.

ISSUE 4.7: HOW SHOULD PATIENTS BE ENCOURAGED OR ASSISTED TO ADHERE TO PREVENTIVE CARE PROCESSES THAT AFFECT OUTCOMES OR COSTS?

OPTION 4.7.1: Payers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes required or recommended by their health care provider.

OPTION 4.7.2: Payers should provide financial incentives to providers based on the level of patient involvement in care planning and/or patient adherence with care processes.

OPTION 4.7.3: Providers should provide financial incentives to patients (e.g., bonuses or reduced copays) for adherence with care processes required or recommended by the provider.

OPTION 4.7.4: Providers should establish proactive systems for educating, monitoring, and encouraging patient adherence, but no explicit financial incentives should be provided to patients.

2. Example of a Possible Payment System for Preventive Care

The following is just one *example* of how the options from the issues described above could be combined into a new method of payment for preventive care.

Method of Payment

- A single provider would be designated as the preventive care manager for an individual and be paid a periodic, prospectively defined Preventive Care Management Payment (CMP) to cover a full range of preventive care services for the patient, with the amount adjusted for the age/risk of the patient. In addition, the preventive care manager would be paid on a fee-for-service basis for actual preventive services provided beyond basic care management (e.g., immunizations). These payments would not be expected to cover either minor or major acute episodes, or prevention associated with management of a chronic condition, which would be covered under other payment systems.

Defining a Recommended Base Payment Amount

- A recommended amount for the Preventive Care Management Payment (CMP) and fees for prevention services would be established by a regional public/private collaborative (involving both payers and providers) based on the patient's age and risk factors.
- The recommended CMP amount and service fees would be based on the estimated cost of delivering the care management and prevention elements of the Clinical Practice Guideline (where one exists) for patients of that age and risk level.
- The CMP would include the estimated costs of services by all providers involved in the preventive care, along with a standard allocation of the payment to individual providers based on the proportion of the overall cost attributable to each provider.

Defining the Actual Base Payment Amount

- Providers or groups of providers would define and announce their actual CMP and service fees (i.e., their "price") for a particular age/risk combination as a percentage of the suggested CMP and fees. Providers could charge different amounts to different payers, including individuals self-paying for care.
- Groups of providers could agree to share the CMP in any way they wished, either based on the standard allocation or a different allocation (e.g., based on cost savings achieved beyond the estimated costs of care). In the absence of such an agreement, the payer would pay each provider their standard allocation of the CMP times the provider's percentage discount/premium.

Conditions for Receiving the Base Payment Amount

- Patients would be entered into a regional registry so that outcomes could be tracked for purposes of measuring performance.

- The CMP would be made on a monthly basis to the provider serving as the patient's preventive care manager in order to provide all preventive care. Service fees would be paid based on billings from the preventive care manager.
- Retroactive adjustments to payments would be made for cases where all mandatory care elements of the Clinical Practice Guideline for patients of that age and with those risk factors had not been provided, unless the provider certified that a particular element was contra-indicated for the patient in question.
- Payment would not depend on which health care professional provided the care (as long as the professional was licensed to do so), or when or where the care was provided (e.g., in one office visit, multiple office visits, in the home, etc.).

Adjustments to the Base Payment Amount

- The CMP amount would be adjusted periodically in response to updates in Clinical Practice Guidelines, the discounts offered by providers, new technologies, inflation, etc.
- Providers would be permitted to revise their actual CMP rates upward at most yearly, but would be encouraged to revise them downward whenever possible.
- No adjustment in payment would be made for patients requiring significantly more services or costs than were assumed in computing the base payment level, but the outlier cases would be documented and used to adjust the age/risk categories and/or future base payment levels in the next year.

Performance Measurement and Incentives

- The preventive care manager would report publicly and receive a bonus payment based on the level of outcomes for patients paid for under the CMP and/or the level of provider compliance with non-mandatory processes under the Clinical Practice Guideline.
- The amount of the bonus would be based on a portion of the present value of avoided costs associated with the improved outcomes or process compliance. (E.g., if the rate of acute episodes for patients declined, then the bonus payment would be based on a portion of the estimated cost of the avoided payments.)
- Groups of providers could agree to share the bonus payment in any way they wished.

Encouraging Patients to Promote Quality and Cost Containment

- Patients using the highest-quality, lowest-cost providers would have no copayments.
- Patients would also receive a financial reward based on adherence with both processes and outcomes (e.g., stopping smoking, getting immunizations, lowering cholesterol level) recommended by their preventive care manager.

VII. Incentives for Performance Beyond Basic Payment Structures

Section VI dealt with issues associated with the first key question defined in the Introduction: *What changes should be made in current healthcare payment systems in order to eliminate (or significantly reduce) the current penalties and disincentives for higher-quality, lower-cost healthcare?*

This Section deals with issues associated with the second key question: *What additional rewards or incentives, if any, should be included in healthcare payment systems in order to encourage higher quality, lower-cost healthcare?* Issues 1.11, 2.7, 3.7, and 4.5 in Section VI asked generally *whether* incentives should be provided, but not *how* they should be structured. This Section addresses the following nine issues associated with the details of how incentives should be structured, assuming that some incentives are to be provided.

- **5.1 How should payments be changed based on provider compliance with non-mandatory processes?**
- **5.2 How should payments be changed based on provider achievement of better patient outcomes?**
- **5.3 How should payments be changed based on reduced utilization of services (or otherwise lower costs or slower growth in costs)?**
- **5.4 How should payments be changed based on achievement of higher patient satisfaction levels?**
- **5.5 Should payments be changed based on any other situations?**
- **5.6 What threshold of performance should trigger payment changes?**
- **5.7 How large should rewards or penalties be relative to base payment levels?**
- **5.8 How should high-cost patients be protected against exclusion from care?**
- **5.9 Should there be any adjustment in payment levels to reflect costs of information technology that providers need to comply with requirements for reporting on processes, outcomes, patient satisfaction, or reduced utilization/cost?**

This Section is not differentiated by the different types of patients/conditions that distinguished the preceding Section. However, the decisions about each of the issues here will likely differ for each category of patient/condition and will depend on the specific payment system designed for that category.

ISSUE 5.1: HOW SHOULD PAYMENTS BE CHANGED BASED ON COMPLIANCE WITH NON-MANDATORY PROCESSES?

Issues 1.9, 2.6, 3.5, and 4.4 in Section VI asked whether any processes should be considered mandatory in order for a provider to receive payment. This issue asks whether and how payments should be changed based on compliance with processes that are not viewed as mandatory in order to receive the base payment.

OPTION 5.1.1: Bonus payments above the base payment level should be awarded to providers that demonstrate higher compliance with non-mandatory care guidelines in all diagnosis/severity categories where such guidelines exist.

OPTION 5.1.2: Bonus payments above the base payment level should be awarded to providers that demonstrate higher compliance with non-mandatory care guidelines only for diagnosis/severity categories where outcomes cannot be effectively measured.

OPTION 5.1.3: Reductions below the base payment level should be made for providers that demonstrate poor compliance with non-mandatory care guidelines.

OPTION 5.1.4: Payment levels should not be changed for higher or lower compliance with non-mandatory care guidelines, but compliance rates should be publicized for use by payers and patients in determining which provider to use. (Rewards or penalties could still be provided based on differences in patient outcomes, as discussed in Issue 5.2.)

See Issues 5.6 and 5.7 below regarding the threshold of performance for bonus payments and the amount of bonus payments.

ISSUE 5.2: HOW SHOULD PAYMENTS BE CHANGED BASED ON ACHIEVEMENT OF BETTER PATIENT OUTCOMES?

OPTION 5.2.1: Bonus payments above the base payment level should be awarded to providers that achieve better outcomes for patients in a particular diagnosis/severity category.

OPTION 5.2.2: Reductions in payment below the base payment level should be made to providers that achieve poorer outcomes for patients in a particular diagnosis/severity category.

OPTION 5.2.3: Payment levels should not be changed for better or worse outcomes, but outcomes should be publicized for use by payers and patients in determining which provider to use.

ISSUE 5.3: HOW SHOULD PAYMENTS BE CHANGED BASED ON REDUCED UTILIZATION OF SERVICES (OR OTHERWISE LOWER COSTS OR SLOWER GROWTH IN COSTS)?

OPTION 5.3.1: Bonus payments above the base payment level should be awarded to providers or groups of providers that achieve lower levels of utilization for patients in a particular diagnosis/severity category.

OPTION 5.3.2: Reductions in payment below the base payment level should be made to providers or groups of providers that have higher levels of utilization for patients in a particular diagnosis/severity category.

OPTION 5.3.3: Bonuses or reductions in payment should be made based on differences in outcomes that have a direct relationship to long-term and indirect costs for the payer or patient, e.g., lengths of stay, readmission rates, etc.

See Section II-E. for a discussion of different categories of costs.

OPTION 5.3.4: Bonuses in payment should not be explicitly based on factors related to utilization or costs; providers should reflect higher efficiency and lower costs through lower prices or combined price packages (e.g., capitation-type arrangements), and payers should reward providers that offer lower prices by encouraging or requiring patients to use these providers rather than higher-cost providers.

ISSUE 5.4: HOW SHOULD PAYMENTS BE CHANGED BASED ON ACHIEVEMENT OF HIGHER PATIENT SATISFACTION LEVELS?

OPTION 5.4.1: Bonus payments above the base payment level should be awarded to providers that demonstrate higher levels of patient satisfaction within a particular diagnosis/severity category.

OPTION 5.4.2: Reductions below the base payment level should be made for providers that demonstrate lower levels of patient satisfaction within a particular diagnosis/severity category.

OPTION 5.4.3: Payment levels should not be changed for higher or lower levels of patient satisfaction, but patient satisfaction levels should be publicized for use by payers and patients in determining which provider to use.

ISSUE 5.5: SHOULD PAYMENTS BE CHANGED BASED ON ANY OTHER SITUATIONS?

OPTION 5.5.1: Payers should provide financial incentives to providers to encourage them to discuss treatment options with patients and help patients choose the most cost-effective treatment options.

ISSUE 5.6: WHAT THRESHOLD OF PERFORMANCE SHOULD TRIGGER PAYMENT CHANGES?

These options would be applicable to any of the bonus/penalty systems established under Issues 5.1 – 5.5. NOTE: Options are described in terms of bonus payments, but similar options can be defined for payment reductions if the options involving penalties in Issues 5.1 – 5.5 are chosen.

OPTION 5.6.1: An absolute threshold of performance should be established at a high level, and bonus payments should only be awarded for performance above that level. The threshold could initially be based on current provider performance (e.g., the 80^{th} or 90^{th} percentile), but would not be reduced even if provider performance decreased. The threshold could be increased in the future, either based on demonstrated improvements in performance by providers or based on a desire by payers to encourage performance improvements.

OPTION 5.6.2: An absolute threshold of performance should be established at a moderate level, and bonus payments should only be awarded for performance above that level. The threshold could initially be based on current provider performance (e.g., the 50^{th} percentile), but would not be reduced even if provider performance decreased. The threshold could be increased in the future, either based on demonstrated improvements in performance by providers or based on a desire by payers to encourage performance improvements.

OPTION 5.6.3: A relative threshold of performance should be established at a high level based on the current performance of providers (e.g., the 80th or 90th percentile of current provider performance), and bonus payments should only be awarded for performance above that level. The threshold would be adjusted periodically based on the actual performance of providers and could be increased or decreased if the performance level of the best providers increases or decreases.

OPTION 5.6.4: A relative threshold of performance should be established at a moderate level based on the current performance of providers (e.g., the 50th percentile of current provider performance), and bonus payments should only be awarded for performance above that level. The threshold would be adjusted periodically based on the actual performance of providers and could be increased or decreased if the performance level of the best providers increases or decreases.

A moderate threshold enables providers to receive rewards for smaller improvements in performance than does a high threshold. An absolute threshold gives providers a definitive target to aim for, whereas with a relative threshold, a provider may improve performance significantly, but fail to receive a bonus payment if other providers also improve by similar or greater amounts.

OPTION 5.6.5: The threshold of performance should be the provider's own prior performance, and bonus payments should be awarded for improvements in performance above the previous level.

ISSUE 5.7: HOW LARGE SHOULD REWARDS OR PENALTIES BE RELATIVE TO BASE PAYMENT LEVELS?

OPTION 5.7.1: The reward for higher performance in a category of diagnosis/severity should be a relatively small percentage of the base payment level for that category (e.g., less than 10%). Rewards should be proportionately higher for higher levels of performance above the minimum threshold.

OPTION 5.7.2: The reward for higher performance in a category of diagnosis/severity should be a relatively large percentage of the base payment level for that category (e.g., 10-50%). Rewards should be proportionately higher for higher levels of performance above the minimum threshold.

OPTION 5.7.3: The reward for higher performance in a category of diagnosis/severity should be a relatively small percentage of the base payment level for that category (e.g., less than 10%). Rewards should be the same for all providers performing above the minimum threshold.

OPTION 5.7.4: The reward for higher performance in a category of diagnosis/severity should be a relatively large percentage of the base payment level for that category (e.g., 10-50%). Rewards should be the same for all providers performing above the minimum threshold.

OPTION 5.7.5: The reward for higher performance in a category of diagnosis/severity should be based on a portion of the estimated reductions in total costs to payers from the higher performance levels (e.g., if hospital readmission rates are lower, the reward would be a proportion of the estimated savings to the payer from fewer readmissions).

If rewards are proportional to reductions in costs to payers, they would also likely be proportional to reduced revenues to the provider, thereby offsetting some of the inherent financial disincentive that providers experience when they improve outcomes in ways that also reduce their revenues.

ISSUE 5.8: HOW SHOULD HIGH-COST PATIENTS BE PROTECTED AGAINST EXCLUSION FROM CARE?

OPTION 5.8.1: Bonus payments above the base payment level should be awarded to providers that demonstrate significantly higher average levels of patient severity (upon admission) within a particular diagnosis/severity category.

OPTION 5.8.2: Reductions below the base payment level should be made for providers that demonstrate significantly lower average levels of patient severity (upon admission) within a particular diagnosis/severity category.

OPTION 5.8.3: No adjustments in payment should be made. Other mechanisms should be used to protect patients against inappropriate exclusion from care.

ISSUE 5.9: SHOULD THERE BE ANY ADJUSTMENT IN PAYMENT LEVELS TO REFLECT COSTS OF INFORMATION TECHNOLOGY THAT PROVIDERS NEED TO COMPLY WITH REQUIREMENTS FOR REPORTING ON PROCESSES, OUTCOMES, PATIENT SATISFACTION, OR REDUCED UTILIZATION/COST?

OPTION 5.9.1: No adjustment in payment levels should be made to reflect costs of information technology needed for compliance, particularly if providers receive higher payments for improved performance.

OPTION 5.9.2: No adjustment in payment levels should be made to reflect costs of information technology needed for compliance, but a loan program should be established to enable small providers to finance the costs of technology acquisition.

OPTION 5.9.3: A cost-sharing arrangement should be established between payers and providers to help cover the costs of information technology that enables compliance monitoring.

VIII. Patient Categories, Care Guidelines, Costs, Measures of Performance, and Transparency

To varying degrees, Sections VI and VII presume the existence of:

- Categories of diagnosis and patient severity (and age and risk) for which payment levels can be consistently established;
- Guidelines for care (often called Clinical Practice Guidelines) for each category of diagnosis and patient severity;
- Estimates of the cost to providers of following guidelines for care in an efficient manner;
- Performance measures for each category of diagnosis and patient severity; and
- Methods of collecting and reporting on performance measures.

In many regions of the country, systems are in place for one or more of these activities, but in others, they are not. In addition, concerns have been raised about whether the processes that are in place at the national level are moving quickly enough. This section discusses these issues and options for addressing them.

ISSUE 6.1: HOW SHOULD DIAGNOSIS/SEVERITY CATEGORIES BE ESTABLISHED?

OPTION 6.1.1: A national public-private collaborative, with representation from both payers and providers, should establish a comprehensive set of Diagnosis/Severity Categories that should be used by all payers and by entities establishing care guidelines and performance measures.

OPTION 6.1.2: Regional or state public-private collaboratives, with representation from both payers and providers, should establish Diagnosis/Severity Categories that should be used by all payers in the affected region/state and by entities establishing care guidelines and performance measures. Efforts should be made to coordinate the development and use of payment/severity categories across states and regions.

OPTION 6.1.3: Each payer should establish Diagnosis/Severity Categories that it will use. Efforts should be made by each payer to coordinate the development and use of payment/severity categories within the local region as well as with payers in other regions.

ISSUE 6.2: HOW SHOULD CARE GUIDELINES BE ESTABLISHED FOR EACH DIAGNOSIS/SEVERITY CATEGORY?

OPTION 6.2.1: One or more national public-private collaboratives, with representation from payers, providers, and consumers, should establish care guidelines (distinguishing mandatory and non-mandatory processes) for each diagnosis/severity category, beginning with the categories affecting the largest numbers of patients and the largest amounts of healthcare expenditures. All payers should use these care guidelines as the basis for

establishing payments and/or performance-based payment adjustments. An aggressive timetable should be established so that guidelines can be used for payment systems.

OPTION 6.2.2: Regional or state public-private collaboratives, with representation from payers, providers, and consumers, should establish care guidelines (distinguishing mandatory and non-mandatory processes) for each diagnosis/severity category where national guidelines have not been adopted. Efforts should be made to coordinate the development and use of care guidelines across states and regions to avoid duplication of effort. All payers in the affected region/state should use these care guidelines as the basis for establishing payments and performance-based payment adjustments. Where care guidelines are developed and utilized in different regions/states, evaluations should be conducted to assess the differences in outcomes resulting from use of different care guidelines.

ISSUE 6.3: HOW SHOULD THE COSTS OF QUALITY CARE BE DETERMINED FOR EACH DIAGNOSIS/SEVERITY CATEGORY?

OPTION 6.3.1: One or more national, state, or regional public-private collaboratives, with representation from payers, providers, and consumers, should determine the actual cost of providing care consistent with care guidelines as currently achieved by the most efficient providers/systems for each diagnosis/severity category, beginning with the categories affecting the largest numbers of patients and the largest amounts of healthcare expenditures. Providers with good cost-accounting systems should contribute cost information on a confidential basis for analysis in determining these costs.

OPTION 6.3.2: One or more national, state, or regional public-private collaboratives, with representation from payers, providers, and consumers, should estimate the achievable cost of providing care consistent with care guidelines for each diagnosis/severity category using management and engineering analyses, beginning with the categories affecting the largest numbers of patients and the largest amounts of healthcare expenditures. Providers with good cost-accounting systems should contribute cost information on a confidential basis for analysis in estimating these costs.

Option 6.3.1 estimates costs based on the best that providers have *actually achieved* to date, whereas Option 6.3.2 estimates costs based on what is *theoretically achievable*.

ISSUE 6.4: HOW SHOULD PERFORMANCE MEASURES BE ESTABLISHED FOR EACH DIAGNOSIS/SEVERITY CATEGORY?

OPTION 6.4.1: One or more national public-private collaboratives, with representation from payers, providers, and consumers, should establish performance measures for each diagnosis/severity category, beginning with the categories affecting the largest numbers of patients and the largest amounts of healthcare expenditures. All payers should use these performance measures as the basis for performance-based payment adjustments. An aggressive timetable should be established so that the performance measures can be used for payment systems.

OPTION 6.4.2: Regional or state public-private collaboratives, with representation from payers, providers, and consumers, should establish performance measures for each diagnosis/severity category where national measures have not been adopted. Efforts should be made to coordinate the development and use of performance measures across states and regions to avoid duplication of effort. All payers in the affected region/state should use these performance measures as the basis for performance-based payment adjustments.

ISSUE 6.5: HOW SHOULD CARE GUIDELINES AND PERFORMANCE MEASURES BE EVALUATED?

To the extent that process measures are used, extensive and rapid research is needed to determine the relationship between processes and outcomes.

OPTION 6.5.1: A well-funded national program of research should be established to continuously evaluate and update care guidelines and to determine the relationship between compliance with care processes and improved patient outcomes.

OPTION 6.5.2: Regional programs of research should be established to conduct studies of the relationship between compliance with care processes and improved patient outcomes.

ISSUE 6.6: WHO SHOULD COLLECT AND REPORT PERFORMANCE MEASURES?

OPTION 6.6.1: Providers (or groups of providers) should be responsible for collecting and reporting on performance measures associated with the patients they care for, consistent with standards established at the national, state, or regional level.

OPTION 6.6.2: Payers should be responsible for collecting and reporting on the performance of providers caring for the patients covered by their payment plans, consistent with standards established at the national, state, or regional level.

OPTION 6.6.3: Regional/State Collaboratives should be responsible for collecting and reporting on the performance of providers providing care in their geographic area, consistent with standards established at the national level.

ISSUE 6.7: SHOULD PERFORMANCE LEVELS OF PROVIDERS ON PROCESS, OUTCOME, PATIENT SATISFACTION, AND/OR EFFICIENCY BE PUBLICLY AVAILABLE?

OPTION 6.7.1: Public disclosure of performance levels should be in the discretion of the individual provider.

OPTION 6.7.2: A regional or state health information organization should collect and publicly report a subset of performance measures in a way that is meaningful to citizens.

OPTION 6.7.3: Payers should make all performance measures used for bonus or penalty payments publicly available.

To the extent that both quality and price (see Issue 6.8) information is made publicly available, it would also be possible to develop and report on measures of value (i.e., the ratio of quality to price).

ISSUE 6.8: SHOULD PROVIDERS' PAYMENT LEVELS (PRICES) FOR DIAGNOSIS/SEVERITY CATEGORIES BE PUBLICLY AVAILABLE?

OPTION 6.8.1: Public disclosure of prices for diagnosis/severity categories should be in the discretion of the provider or the payer.

OPTION 6.8.2: Providers should publish the prices they will charge self-pay patients for each diagnosis/severity category.

OPTION 6.8.3: Providers should publish the range of prices they charge all payers for each diagnosis/severity category.

OPTION 6.8.4: Payers should publish the prices they pay providers for each diagnosis/severity category.

OPTION 6.8.5: A Regional or State public/private collaborative should publish the prices that payers pay providers for each diagnosis/severity category.

To the extent that both price and quality (see Issue 6.7) information is made publicly available, it would also be possible to develop and report on measures of value (i.e., the ratio of quality to price).

Publishing prices for multiple providers can raise anti-trust concerns, so this will need to be done in consultation with the U.S. Attorney General and state Attorney(s) General. Legislation may be needed to provide a safe harbor for such an approach if appropriate benefits can be demonstrated.

IX. Implementation of Changes in Payment Systems

This section addresses issues associated with implementation of whatever payment system is developed based on the issues discussed in Sections VI-VIII.

In addition to reaching consensus on the desired structure of payment systems, it is critical to define a feasible path for actually implementing the changes needed to achieve those structures.

ISSUE 7.1: HOW SHOULD PAYMENT CHANGES BE PHASED IN?

OPTION 7.1.1: Demonstrations of alternative payment systems for particular diagnosis/severity categories should be developed and tested in individual regions of the country. All payers in a region with a demonstration project should pay for patients in the specific diagnosis/severity category using the same basic payment structure, in order to insure that the same incentives exist for all patients in that category and for all providers, and to insure that there are no competitive advantages or disadvantages created for different payers. (This would require waivers or demonstration projects for national payers such as Medicare.) The U.S. Department of Justice should proactively work to provide guidance to payers to avoid anti-trust concerns, and/or recommend legislative modifications to Congress if necessary, in order to enable effective alignment of payment systems. When a region's payment demonstration project proves to be successful, it should be adopted by other regions, and ideally ultimately by all payers in all regions.

OPTION 7.1.2: National payers (e.g., Medicare, national private insurance plans, etc.) should develop and implement new payment systems and then encourage regional payers to adopt them.

ISSUE 7.2: SHOULD PAYMENT CHANGES BE REQUIRED TO BE "BUDGET NEUTRAL?"

"Budget neutral" means that the cost to a payer is no greater or lesser under the new payment system than it would have been under the previous payment system. Budget neutrality is generally viewed as being measured over a one-year timeframe, the typical length of a government budget year or health insurance contract. As noted in Section II-E, a short timeframe can cause distortions in incentives, because some short-run cost savings can lead to longer-run cost increases, and vice versa.

OPTION 7.2.1: Initial demonstrations of alternative payment systems should focus on diagnosis/severity categories where reductions in average expenditures for care seem possible based on the current distribution of costs across providers (i.e., categories where some providers have demonstrated lower costs with equal or better outcomes than others)

OPTION 7.2.2: Initial demonstrations of alternative payment systems should focus on combinations of diagnosis/severity categories where possible reductions in average expenditures in one category will offset possible increases in short-run average expenditures in another (e.g., for categories where

there are significant differences in quality but higher short-run costs for higher quality). Payers (particularly employers, rather than health plans) will also need to explicitly recognize the value of reductions in indirect costs and long-run costs, since some increases in short-run direct costs may be necessary to reduce indirect costs or long-term costs. (See Section II-E.)

ISSUE 7.3: HOW SHOULD THE EFFECTS OF PAYMENT CHANGES BE EVALUATED?

OPTION 7.3.1: A well-funded national program of research should be established to evaluate the effects of new payment systems and identify areas where problems exist or where there are opportunities to further improve value. In addition, a standard set of definitions and measures for evaluations should be established to insure comparability of results across evaluations.

OPTION 7.3.2: Regional programs of research should be established to evaluate the effects of new payment systems and identify areas where problems exist or where there are opportunities to further improve value. A network of researchers should be created in order to establish a standard set of definitions and measures for evaluations in order to promote comparability of results across evaluations.

X. Conclusion

Unfortunately, there are no easy answers regarding which options are best for most of the issues identified in Sections VI – IX. In some cases, one option may seem preferable, but concerns exist about potential unintended consequences. In other cases, there is simply insufficient knowledge or experience as to how providers or patients will respond to enable a preferred option to be identified. This uncertainty is due to the fact that there have been relatively few cases where significantly different payment systems have been attempted, and even fewer where thorough evaluations have been conducted.

One clear conclusion that can be drawn, therefore, is that payment demonstration projects must be developed, implemented, and evaluated in order to make progress on payment reform. There is growing consensus that the serious problems of quality and cost affecting the healthcare system cannot be fixed without fundamental changes in the way the nation pays for health care, and so projects to test and demonstrate alternative payment systems must be a high priority.

A second conclusion is that a wide variety of payment demonstrations are needed. Not only are there many different issues, and multiple options for resolving each of those issues, but every region of the country is different in terms of the number, types, and relationships of health care purchasers, payers, and providers. Just as experimentation and evaluation is a hallmark of evidence-based medicine, experimentation and evaluation will also likely be needed in order to develop the most effective cure for the ills of the payment system.

This leads to a third conclusion that may be surprising for many – the leadership for payment reform demonstrations should come from the regional level, rather than the national level. Health care is a fundamentally regional enterprise, since most providers and even most payers operate exclusively or primarily in metropolitan regions, states, or multi-state areas. Just as there will likely not be any single method of payment that will work for all types of patients and conditions, there may also not be a single type of payment system that will work in all parts of the country.

While payment demonstrations can and should be pursued at the regional level, this does not mean that payment reform should be a parochial enterprise. Indeed, just as medicine itself advances the state-of-the-art through local innovations that are supported, replicated, and evaluated nationally, so too can payment reform be more successful if there is national support for the development, evaluation, and replication of regional payment demonstrations. Both the federal government and private foundations can play a major role in helping to support this.

References

The following is a selection of the many articles and presentations related to the topics discussed in this paper. Abstracts and links for these articles and presentations are available at www.nrhi.org/payment.html.

Problems with Current Payment Systems

- "Aligning Payment Policies With Quality Improvement," in *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine, 2001.
- "When The Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care, " by Paul B. Ginsburg and Joy M. Grossman, *Health Affairs*, Web Exclusive August 9, 2005, pp. 376-384.
- "Primary Care - Will It Survive? " by Thomas Bodenheimer, *New England Journal of Medicine* 355:9, pp. 861-864.
- "Providing Care at the End of Life: Do Medicare Rules Impede Good Care? " by Haiden A. Huskamp, Melinda Beeuwkes Buntin, Virginia Wang, and Joseph P. Newhouse, *Health Affairs*, Volume 20, Number 3, May/June 2001.
- "In Medicare, Let's Start Paying for What We Want, " by Stuart Guterman, *Baltimore Sun*, February 16, 2007.
- "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care, " by Elliott S. Fisher, David E. Wennberg, Therese A. Stukel, Daniel J. Gottlieb, F.L. Lucas, and Etoile L. Pinder, *Annals of Internal Medicine* 2003:138, pp. 273-287.
- "The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care, " by Elliott S. Fisher, David E. Wennberg, Therese A. Stukel, Daniel J. Gottlieb, F.L. Lucas, and Etoile L. Pinder, *Annals of Internal Medicine* 2003:138, pp. 273-287.
- "Regional Variations in Health Care Intensity and Physicians' Perceptions of Care Quality, " Letter from John C. Peirce and response from Brenda Sirovich and Elliott S. Fisher, *Annals of Internal Medicine* 2006:145, pp. 788-789.
- "Variation in the Tendency of Primary Care Physicians to Intervene, " by Brenda E. Sirovich, Daniel J. Gottlieb, H. Gilbert Welch, and Elliott S. Fisher, *Archives of Internal Medicine* 2005:165, pp. 2252-2256.
- "Is Technological Change In Medicine Always Worth It? The Case Of Acute Myocardial Infarction, " by Jonathan S. Skinner, Douglas O. Staiger, and Elliott S. Fisher, *Health Affairs*, 2006:25, pp. w34–w47.
- "The Primary Care-Specialty Income Gap: Why It Matters, " by Thomas Bodenheimer, Robert A. Berenson, and Paul Rudolf, *Annals of Internal Medicine* 146, pp. 301-306, 2007.
- "Preference-Sensitive Care," Dartmouth Atlas Project, 2007.
- "Care Patterns in Medicare and Their Implications for Pay for Performance," by Hoangmai H. Pham, Deborah Schrag, Ann S. O'Malley, Beny Wu, and Peter B. Bach, *The New England Journal of Medicine*, 356:11, pp. 1130-1139, 2007.

Concerns with Pay for Performance Systems

- "Does Pay-for-Performance Improve the Quality of Health Care? " by Laura A. Petersen, LeChauncy D. Woodard, Tracy Urech, Christina Daw, and Supicha Sookanan, *Annals of Internal Medicine* 145:4, pp. 265-272, August 15, 2006.

- "Early Experience With Pay-for-Performance: From Concept to Practice, " by Meredith B. Rosenthal, Richard G. Frank, Zhonghe Li, and Arnold M. Epstein, *JAMA* 294:14, pp. 1788-1793, October 12, 2005.
- "Public Reporting and Pay for Performance in Hospital Quality Improvement, " Peter K. Lindenauer, et al, *New England Journal of Medicine* 356:486-496, February 1, 2007. Also see summary and interview with the authors in "Pay for Performance Linked to Modest Improvements in Hospital Quality, " *Medscape Medical News*, February 2, 2007.
- "Development of Medicare Hospital Value-Based Purchasing Plan: Findings from Environmental Scan," by Cheryl L. Damberg, Melony E.S. Sorbero, Stephanie Teleki, and Ateev Mehrotra, the RAND Corporation, prepared for the CMS VBP Plan Development - 1st Listening Session, January 17, 2007.
- "P4P: Transitional at Best, " by Alice G. Gosfield, *Managed Care Magazine*, January 2005.
- "The Development of a Performance Incentive Program for Hospitals: A Case Study of a Statewide Pay-for-Performance Program in Maine, " by Gino Nalli, Dennis Scanlon, and Douglas Libby, forthcoming.
- "Measuring Performance For Treating Heart Attacks And Heart Failure: The Case For Outcomes Measurement, " by Harlan M. Krumholz, Sharon-Lise T. Normand, John A. Spertus, David M. Shahian, and Elizabeth H. Bradley, *Health Affairs* 26, no. 1 (2007), pp. 75-85.
- "The Impact of Financial Incentives on Quality of Health Care, " R. Adams Dudley, Robert H. Miller, Tamir Y. Korenbrot, and Harold S. Luft," *Milbank Quarterly*, Vol. 76, No. 4, pp. 649-686, 1998.
- "Compliance: Patient Autonomy vs. P4P Imperatives, " by Wayne J. Guglielmo, *Medical Economics*, March 2, 2007.

Goals and Issues for Improved Payment Systems

- "Aligning Payment Policies With Quality Improvement, " in *Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine, 2001.
- "Overview of a Reconfigured Health System," by Harold S. Luft, presented to the Council on Health Care Economics and Policy at the Thirteenth Princeton Conference on Reinventing Health Care Delivery in the 21st Century, May 24-25, 2006.
- "Living Well at the End of Life: Adapting Health Care to Serious Chronic Illnesses in Old Age," by Joanne Lynn and David M. Adamson, RAND Health, 2003.
- "Issues Paper: Medicare Hospital Value-Based Purchasing Plan Development, " CMS Hospital Pay-for- Performance Workgroup, January 17, 2007.
- "Paying for Performance - Risks and Recommendations, " by Elliott S. Fisher, *New England Journal of Medicine* 355:18, pp. 1845-1847.
- "Strategic Choices in Pay-for-Performance Programs, " by James C. Robinson, presented at the February 6, 2006 Pay for Performance Summit.
- "Conceptual Issues in the Design and Implementation of Pay-for-Quality Programs, " by Gary J. Young, Bert White, James F. Burgess, Jr., Dan Berlowitz, Mark Meterko, Matthew R. Guldin, and Barbara G. Bokhour, *American Journal of Medical Quality* 2005:20, May/June 2005, pp. 144-150.
- "Theory and Practice in the Design of Physician Incentives, " by James C. Robinson, *Milbank Quarterly*, 79:2, June 2001.
- "Moving Beyond Round Pegs and Square Holes: Restructuring Medicare to Improve Chronic Care, " by Jennifer L. Wolff and Chad Boult, *Annals of Internal Medicine*, 143:6, pp. 439-445, September 2005.

- "Linking Payment to Long-Term Care Quality: Can Direct Staffing Measures Build the Foundation? " by Debra J. Lipson, Institute for the Future of Aging Services, April 2005.

Options and Proposals for Value-Based Payment Systems

- "Aligning Incentives in the Context of Biomedical Innovation," by James C. Robinson, presentation at the National Pay for Performance Summit, February 16, 2007
- "Getting the Price Right: Medicare Payment Rates for Cardiovascular Services," by Kevin J. Hayes, Julian Pettingill, and Jeffrey Stensland, *Health Affairs*, Vol 26, no. 1, pp. 124-136, January/February 2007.
- "Aligning Incentives in the Context of Biomedical Innovation," by James C. Robinson, presentation at the National Pay for Performance Summit, February 16, 2007.
- "White Paper," Prometheus Payment, Inc., 2006.
- "Payment Reform, " by David W. Plocher, Blue Cross and Blue Shield of Minnesota, PowerPoint Presentation, January 2007.
- "A System in Need of Change: Restructuring Payment Policies to Support Patient Care, " by Neil Kirschner and Robert Doherty, American College of Physicians, 2006.
- "Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care, " by Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, and Laurence B. Gardner, *Journal of General Internal Medicine*, 2007.
- "Care by the Hour, " by Robin Cook, *New York Times*, August 30, 2006.
- "Beyond Managed Long-Term Care: Paying for Home Care Based on Risk of Adverse Outcomes, " by William Weissert, Michael Chernew, and Richard Hirth, *Health Affairs* Vol. 20, No. 1, pp. 172-180, May/June 2001.
- "Redefining and Reforming Health Care for the Last Years of Life, " by Joanne Lynn and David M. Adamson, RAND Corporation, 2006. Also see "Living Well at the End of Life, " by Joanne Lynn and David M. Adamson, RAND Corporation, 2003, and "Sick to Death: Reforming Health Care for the Last Years of Life, " by Joanne Lynn, Palliative Care Policy Center.
- "Realigning Incentives in Fee-For-Service Medicare, " by Stanley S. Wallack and Christopher P. Tompkins, *Health Affairs* 22:4, pp. 59-70, 2003.
- "Gain Sharing: A Good Concept Getting a Bad Name? " by Gail R. Wilensky, Nicholas Wolter, and Michelle M. Fischer, *Health Affairs*, 26, no. 1, w58-w67, December 5, 2006.
- "Creating Accountable Care Organizations: The Extended Hospital Medical Staff , " by Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb, *Health Affairs* Vol. 26, no. 1, pp. w44–w57, January/February 2007.
- "Bundled Medicare Payment for Acute and Postacute Care, " by W. Pete Welch, *Health Affairs*, Vol 17, Issue 6, pp. 69-81.
- "Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery, " by Jerry Cromwell, Debra A. Dayhoff, and Armen H. Thoumaian, *Health Care Financing Review*, Vol 9(1), pp. 41-57, Fall 1997.
- "Administrative Simplification for Medical Group Practices, " Medical Group Management Association, June 2005.
- "Redesigning Medicare Inpatient PPS to Adjust Payment for Post-Admission Complications, " by Richard F. Averill, James C. Vertrees, Elizabeth C. McCullough, John S. Hughes, and Norbert I. Goldfield, *Health Care Financing Review*, Spring 2006, pp. 83-93.

Payment Reform Examples

Note: Examples below were gathered from the Commonwealth Fund's Quality Matters on Payment Reform and the NRHI website. Additional information provided by individual case examples websites.

1. **Redefining Health Care: Creating Value-base Competition on** Results (from CMWF's Quality Matters)

   Michael Porter, M.B.A., Ph.D., and Elizabeth Teisberg, M.S., Ph.D., the authors of Redefining Health Care: Creating Value-based Competition on Results, have put forward another proposal. Porter, a professor at Harvard Business School, and Teisberg, an associate professor at the University of Virginia's Darden Graduate School of Business, advocate reorganizing medical care around specific conditions and reporting risk-adjusted outcomes for those conditions as a means of orienting the system away from competition on price and toward competition on value to patients. If value were judged by outcomes per dollar spent, efficiency and innovation would improve and costs would decline as they have in other industries, they say. Medical practices would be organized around conditions, rather than specialties, which would encourage depth of practice rather than breadth. Even primary care practices would be segmented into practices that specialize in diagnoses and those that specialize in early-stage treatment. The Porter/Teisberg model also anticipates that reimbursement will be structured around episode-of-care payments.

   Such a model is predicated on the notion that physicians will be financially rewarded for making these adjustments. "The problem is that if the payment system doesn't respond to that, they get hurt," says Harold Miller, strategic initiatives consultant for the Pittsburgh Regional Health Initiative, a coalition of hospitals, insurers, employers, and clinicians in Southwestern Pennsylvania. Payment and reorganization "have to proceed together."

   Contact: TeisbergE@virginia.edu, mporter@hbs.edu
   Website: www.hbs.edu/index.html

2. **Prometheus Payment Model – Episode of Care**

   Prometheus Payment, Inc. is developing a new system of payment based on what evidence-based medicine defines as appropriate for a patient with a particular condition. The system involves taking the Clinical Practice Guideline for the condition, estimating the cost of delivering the care in the Guideline, and then turning that into an "Evidence-Based Case Rate" to cover all of the care by all of the providers who will be involved with the patient's care. 10-20% of the payment amount is withheld and placed in a performance contingency fund which is paid to providers based on their performance on a multi-factor scorecard. A White Paper describing the plan is available here. A presentation describing the status of planning for the system with examples of how the detailed specifications would be developed is available here.

   Contact: Francois de Brantes, francois.debrantes@bridgestoexcellence.org
   Website: http://www.prometheumpayment.org

3. "**Payment Reform**," by David W. Plocher, Blue Cross and Blue Shield of Minnesota, PowerPoint Presentation, January 2007
   This presentation outlines the rationale for episode of care payment and describes both the Prometheus approach and the approach developed by the Oxford Health Plan in 1998.

4. **Medicare Payment Rates for Cardiovascular Services – Episode of Care Payment**

"Getting the Price Right: Medicare Payment Rates for Cardiovascular Services," by Kevin J. Hayes, Julian Pettingill, and Jeffrey Stensland, *Health Affairs*, Vol 26, no. 1, pp. 124-136, January/February 2007.
"Specialized, physician-owned cardiac hospitals have grown rapidly. Physicians have also expanded their capability to provide cardiovascular diagnostic services in their offices. In this paper we consider evidence of errors in Medicare's prices for hospital care and physician services and discuss ways to improve the accuracy of those prices. We find that recent proposals to change the inpatient prospective payment system would help dampen hospitals' financial incentives to favor some kinds of patients and related investments. For the physician fee schedule, we suggest that the Centers for Medicare and Medicaid Services (CMS) review the accuracy of prices for high-growth diagnostic services."

5. **American College of Physicians – Advanced Medical Home**

"A System in Need of Change: Restructuring Payment Policies to Support Patient Care," by Neil Kirschner and Robert Doherty, American College of Physicians, 2006.
This paper describes the recommendations of the American College of Physicians (ACP) for restructuring the fee-for-service payment system for physicians. ACP recommends that physician practices that are qualified to serve as an "Advanced Medical Home" (AMH) should be paid through a four-part structure: (1) A prospective, bundled structural practice component that covers the practice overhead costs linked to providing AMH services that are not currently paid under the present system; (2) a prospective, bundled care coordination component that recognizes the work value of physician and nonphysician clinical and administrative care coordination activities that take place outside of face-to-face visits and that are not currently paid under the present system; (3) a visit-based fee-for-service component that recognizes visit-based services that are currently paid under the present system; and (4) a performance-based component that recognizes achievement of quality and efficiency goals.

6. **Comprehensive Payment for Comprehensive Care –Physician Payment**

"Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care," by Allan H. Goroll, Robert A. Berenson, Stephen C. Schoenbaum, and Laurence B. Gardner, *Journal of General Internal Medicine*, 2007.
"Primary care is essential to the effective and efficient functioning of health care delivery systems, yet there is an impending crisis in the field due in part to a dysfunctional payment system. We present a fundamentally new model of payment for primary care, replacing encounter-based reimbursement with comprehensive payment for comprehensive care. Unlike former iterations of primary care capitation (which simply bundled inadequate fee-for-service payments), our comprehensive payment model represents new investment in adult primary care, with substantial increases in payment over current levels. The comprehensive payment is directed to practices to include support for the modern systems and teams essential to the delivery of comprehensive, coordinated care. Income to primary physicians is increased commensurate with the high level of responsibility expected. To ensure optimal allocation of resources and the rewarding of desired outcomes, the comprehensive payment is needs/risk adjusted and performance-based. Our model establishes a new social contract with the primary care community, substantially increasing payment in return for achieving important societal health system goals, including improved accessibility, quality, safety, and efficiency. Attainment of these goals should help offset and justify the costs of the investment. Field tests of this and other new models of payment for primary care are urgently needed."

7. **Paying for Home Care Based on Risk of Adverse Outcomes – Home Health Care Payment**

"Beyond Managed Long-Term Care: Paying for Home Care Based on Risk of Adverse Outcomes," by William Weissert, Michael Chernew, and Richard Hirth, *Health Affairs* Vol. 20, No. 1, pp. 172-180, May/June 2001.
"Evaluations of home care for chronically ill elderly people have shown disappointing results for many years. Improvements in outcomes have been slight and costs high. We offer a system for setting budget targets based upon effectiveness of home care in mitigating certain adverse outcomes, the risk of those outcomes occurring, and the economic value of avoiding those outcomes. We believe that such a budgeting system will encourage improved measurement of outcomes andmore rigorous justification for expenditures. Moreover, such a system is designed to reallocate resources to higher-risk patients and those more likely to benefit, focusing caregiving on specific outcomes and improving those outcomes."

8. **End-of-Life Care Payment**

"Redefining and Reforming Health Care for the Last Years of Life," by Joanne Lynn and David M. Adamson, RAND Corporation, 2006.
"...health care insurers, such as Medicare and the Veterans Health Administration, should structure payment systems to ensure that patients living with serious, eventually fatal chronic illness routinely receive comprehensive, coordinated care. In fact, these agencies could design payment systems that discourage the kind of episodic treatment that made sense 40 years ago but no longer works best today. Instead, an elderly person with a serious chronic illness should have a health care team that stays with the patient through the rest of his or her life. That team would provide symptom management treatment, planning for potential complications, self-care education to the patient, support services to the family caregivers, and rapid response to the home when needed. Third, health care organizations and practitioners should measure their service outcomes and use quality improvement to increase the reliability of care. Finally, family caregivers will need to mobilize to place pressure on policymakers to enact successful reforms and on health care providers to make changes."
Also see "Living Well at the End of Life," by Joanne Lynn and David M. Adamson, RAND Corporation, 2003, and "Sick to Death: Reforming Health Care for the Last Years of Life," by Joanne Lynn, Palliative Care Policy Center.

9. **Medicare Fee-For-Service Shared Savings Models**

"Realigning Incentives in Fee-For-Service Medicare," by Stanley S. Wallack and Christopher P. Tompkins, *Health Affairs* 22:4, pp. 59-70, 2003.
"This paper proposes Medicare payment reform built on the fee-for-service system, with incentive payments to eligible provider organizations determined by their rate of increase in cost per patient compared to the overall growth rate in the community. By planning and monitoring how care patterns are altered to achieve greater efficiency, policy-makers can align the incentives of Medicare and the provider organization better than using either fee-for-service or capitation alone. This reform, unlike capitation, maintains Medicare's historical role as insurer and focuses providers on managing care."

10. **Gain Sharing**

"Gain Sharing: A Good Concept Getting a Bad Name?," by Gail R. Wilensky, Nicholas Wolter, and Michelle M. Fischer, *Health Affairs*, 26, no. 1, w58-w67, December 5, 2006.
"The introduction of diagnosis-related groups (DRGs) created a clear misalignment between the incentives facing hospitals and those facing physicians. The interest in gain sharing that

developed in the 1990s represented an attempt by physicians to extract and hospitals to offer some of the savings being produced by physicians. Advisory bulletins by the Office of Inspector General (Department of Health and Human Services) quickly put a stop to further interest in these strategies. Newer, narrowly defined types of gain sharing have been under consideration. More broadly defined strategies that will be tested under a new Centers for Medicare and Medicaid Services demonstration are more promising."

CMS Physician Hospital Collaboration Demo – Gain Sharing
CMS has been experimenting with other means of encouraging collaboration between physicians and hospitals, including a gainsharing program that enables physicians and hospitals to share the savings from improved operational performance without violating the federal anti-kickback statute. The Physician Hospital Collaboration Demonstration, which will last three years, allows hospitals to share savings from quality and efficiency initiatives, provided payments do not exceed 25 percent of physician income for those services.

Website:
http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1186653

11. **Extended Hospital Staff Model - Bundled Payment and Accountability Systems** (from CMWF's Quality Matters) "Creating Accountable Care Organizations: The Extended Hospital Medical Staff ," by Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum, and Daniel J. Gottlieb, *Health Affairs* Vol. 26, no. 1, pp. w44–w57, January/February 2007.

    One proposal for increasing providers' accountability for their performance is the extended hospital staff model developed by Elliott Fisher, M.D., M.P.H., a Dartmouth Medical School professor whose work established that higher spending in the Medicare program is associated with the overuse of supply-sensitive services, such as specialist physician services, and not correlated with quality. His model calls for organizing physicians and hospitals nationwide into 5,000 virtual (or real) groups, known as "accountable care organizations," and publicly reporting their outcomes and costs to allow for comparisons.

    Physicians would be assigned to a hospital based on their direct and indirect referral patterns, and would be judged together with the hospital on quality and cost measures. The public reporting of these results and the shared responsibility for outcomes, capacity utilization, and cost would compel independent physicians and hospitals to work together to reduce excess utilization and cost, Fisher argues.

    Financial incentives would follow and could be structured in a variety of ways, including shared savings or pay-for-performance bonuses, among other means, Fisher says.

    Such a system would produce the large sample sizes necessary for statistical analysis, as well as a means of longitudinal measurement, and ease the reporting burden on the government by focusing the accountable care organizations around 5,000 hospitals, rather than 500,000 physicians.

    But the model faces significant challenges. As Fisher himself notes, physician practices are characterized by a culture of autonomy and are likely to resist the notion of shared responsibility. Another challenge is the lack of refined quality measures across providers.

    Contact: Elliot Fisher, elliott.fisher@dartmouth.edu

12. Bundled Medicare Payments

"Bundled Medicare Payment for Acute and Postacute Care," by W. Pete Welch, *Health Affairs*, Vol 17, Issue 6, pp. 69-81.
"One legislative policy option for controlling postacute care costs is for Medicare to make a 'bundled' payment to hospitals to cover episode costs: acute plus postacute care costs. But a bundled payment might not match the costs of treatment as well as payment now does under Medicare's prospective payment system (PPS). Simulating hospital margins with and without postacute care costs, this paper finds that risks to the typical hospital would not increase under postacute care bundling. A central characteristic of a bundled payment is that it would cover multiple providers. From this characteristic comes bundled payment's major strength: cost containment."

"Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery," by Jerry Cromwell, Debra A. Dayhoff, and Armen H. Thoumaian, *Health Care Financing Review*, Vol 9(1), pp. 41-57, Fall 1997.
"In 1991 the Health Care Financing Administration (HCFA) began the Medicare Participating Heart Bypass Center Demonstration, in which hospitals and physicians are paid a single negotiated global price for all inpatient care for heart bypass patients. During the first 27 months of the demonstration, the Government and beneficiaries together saved more than $17 million on bypass surgery in four participating institutions. Average total cost per case fell in three of the four hospitals during the 1990-93 period as the alignment of physician and hospital incentives resulted in physicians changing their practice patterns to shorten stays and reduce costs."

13. Standard Physician Fee Schedule

"Administrative Simplification for Medical Group Practices," Medical Group Management Association, June 2005.
Recommendation #5 calls for establishing a standard physician fee schedule (and similar uniform fees for services provided by hospitals and other providers) with uniform base fees paid for a particular CPT code for all insurers. According to the proposal, such a “singlefee schedule” would not mean that every practice would be paid the same or that practices would not have the opportunity to differentiate themselves from their competitors. The paper proposes that a statewide organization could negotiate a single base-fee schedule with all payers in the state and agree on a standard set of additions to the base fees to reward groups that meet patient needs. This would eliminate the patchwork of base rates and incentives, varying by payer, which providers currently face. The paper also calls for standardizing pay for performance incentives, so that all insurers would make higher payments to practices meeting a common set of performance incentive measures. Recommendation #6 calls for standardizing clinical guidelines for common conditions by having plans and local practitioners in a geographic region collaboratively develop and maintain guidelines, with plans in each market collaboratively financing the effort.

Websites: http://www.mgma.com/about/default.aspx?id=788

14. Payments for Adverse Events

"Redesigning Medicare Inpatient PPS to Adjust Payment for Post-Admission Complications," by Richard F. Averill, James C. Vertrees, Elizabeth C. McCullough, John S. Hughes, and Norbert I. Goldfield, *Health Care Financing Review*, Spring 2006, pp. 83-93.
"Under the Medicare diagnosis-related group (DRG) based inpatient prospective payment system (IPPS), payments to hospitals can increase when a post-admission complication

occurs. This article proposes a redesign of IPPS that reduces, but does not eliminate, the increase in payment due to post-admission complications. Using California data that contained a specification of whether each diagnosis was present at admission, and applying a conservative approach to identifying potentially preventable complications, the impact of post-admission complications on DRG assignment was determined. Based on the redesigned IPPS, the increase in Medicare payments due to post-admission complications was reduced by more than one billion dollars annually.

15. Geisinger Warranty Concept

Geisinger Health System, a hospital group in central Pennsylvania, is "trying to address what it views as a fundamental flaw in the typical medical reimbursement system" by offering heart bypass surgery patients a "guarantee of its workmanship": 90 days of follow-up treatment at no additional cost, the *New York Times* reports. The program, called ProvenCare, uses a 40-step system based on best practices for pre- and post-operative treatment. Geisinger physicians also developed procedures to "ensure the steps would always be followed, regardless of which surgeon or which one of its three hospitals was involved."

When the program began, physicians used all 40 steps in 59% of heart bypass surgeries, but now "an operation is canceled if any of the pre-operative measures have been forgotten," according to the *Times*. Under a pilot program, the hospital charges an insurer a flat fee for the surgery and half the amount it has determined as "the historical cost of related care for the next 90 days," the *Times* reports. The results of the Geisinger experiment, presented last month at a meeting of the American Surgical Association, showed that since the program's inception in February 2006, patients were less likely to return for intensive care, spent fewer days in the hospital and were more likely to go directly home from the hospital rather than to a nursing home.

16. Vermont Blueprint for Health – Chronic Care

The Vermont Blueprint for Health is a vision, a plan and a statewide partnership to improve health and the health care system for Vermonters. The Blueprint provides the information, tools and support that Vermonters with chronic conditions need to manage their own health – and that doctors need to keep their patients healthy. The Blueprint is working to change health care to a system focused on preventing illness and complications, rather than reacting to health emergencies.

Strategic plan lays out broad goal for “sustainable payment methods for physicians and other health care providers that enable compliance with evidence-based care delivery and care management…” by January 1, 2012. A comprehensive analysis of payment options and “Pay for Performance ad other payment mechanisms that provider rewards and incentives for high performance,” informed by Medicare experience, must be completed by July 1, 2008. By October 1, 2008, the Commissioner of Health will make payment recommendations to the legislature and other stakeholders. (From January 2007 Report to the Legislature of Act 191: http://healthvermont.gov/admin/legislature/documents/Blueprint_leg_report.pdf)

Website: http://healthvermont.gov/blueprint.aspx

Payment Reform

Background Information Prepared for the Health Care Transformation Task Force
by Minnesota Department of Health Staff
September 17, 2007

The concept of health care payment reform is currently a topic of considerable attention among policymakers who want to find ways to improve health care quality and health outcomes while controlling health care cost growth. Central goals of payment reform include changing financial incentives for health care providers and patients in ways that:

- Reward higher quality, instead of volume of services;
- Reduce fragmentation of care and promote a more coordinated, team-based approach to care;
- Encourage greater efficiency in resource use;
- Emphasize and reward prevention and management of chronic disease; and
- Avoid the perverse incentives caused by payment rates that are too high for some types of services and too low for others.

This background paper presents an overview of several different types of payment reform, with specific case study examples where they are available; however, there is little systematic evidence to date of the impact of the types of major payment reforms that are currently being considered.

The types of payment reform included in this background paper include:

- Bundling payments for groups of services;
- Providing explicit payment for care coordination and management services that have the potential to reduce costs by avoiding preventable and costly complications; and
- Providing incentives to improve system efficiency.

For purposes of this background paper, pay for performance is not included as a type of payment reform. The reason for this is that most pay for performance mechanisms simply pay a bonus on top of existing payments, without fundamentally changing the ways that health care services are paid for. In fact, many experts believe that pay for performance is best viewed as a short-term strategy for improving quality until new systems can be developed that fundamentally change incentives throughout the health care system.

A much more extensive discussion of the various types of payment reform, the goals of each, and the potential advantages and disadvantages associated with each can be found in Harold Miller's paper "Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform," forthcoming from the Commonwealth Fund.

Bundling Payments for Groups of Services

Current payment systems generally are structured in a way that includes (1) fixed payments for all non-physician services provided during an inpatient hospital stay (with variation based on diagnosis and severity of illness), and (2) fees paid according to a fixed fee schedule for each individual service provided by a physician (for either inpatient or outpatient care) or by a hospital outpatient clinic. A major criticism of current payment systems is that they reward providers for delivering more services than necessary, and penalize providers who try to improve efficiency by delivering fewer services.

One approach to changing incentives in the current system that reward volume rather than quality is to bundle payments for groups of services. This idea is essentially an extension of current methods of paying for inpatient hospital care (a fixed price for the entire "bundle" of services delivered during a hospital stay) beyond the inpatient setting to include care provided in other settings as well. The bundled payments can be made to a single organization (e.g., an integrated care delivery system) or for a single episode of care involving multiple providers.

The "unit" of service in many proposals to bundle payments is the episode of care. The definition of an "episode" may depend on the type of health condition: for example, for a chronic condition such as diabetes, an episode could include all care provided during a fixed time period (e.g., six months or a year); for acute conditions like heart attacks, an episode would include all services provided from the beginning to the end of treatment (e.g., care prior to hospitalization, hospitalization, and post-hospitalization care for a certain period of time).

Compared with a fee for service payment system, where the provider is reimbursed according to the volume of services provided, a payment system based on bundles of care involve higher financial risk for providers; however, providers also have more to gain by improving care quality in ways that reduce the amount of care needed and lower costs. This type of system is also different than traditional capitation payment, since the payment amount is based on the conditions/diseases that the patient has, rather than being a fixed amount for each patient, regardless of their health status.

Example 1: Geisinger Health System

Geisinger Health System (GHS) is a large integrated health care system in Pennsylvania that includes a health plan, three hospitals, and over 50 office practices. Beginning in February 2006, GHS placed a 90-day "warranty" for care provided to all non-emergency coronary artery bypass graft (CABG) patients and began charging a single price for a bundle of services that included hospitalization and all related care for a 90-day period, including any readmissions for complications. The price for this bundle of services was set equal to the estimated cost of a typical hospitalization for CABG surgery plus half of the average cost of post-acute care for the 90-day period following surgery. To define appropriate interventions and prevent complications, GHS' cardiac surgeons agreed on

40 essential steps for CABG procedures, and GHS set a goal of reducing its post-discharge costs for CABG patients by 50%.[1,2]

A preliminary study of outcomes and costs for patients treated under "warranty" between February and October of 2006 compared with patients treated in 2005 showed that "warranty" patients experienced:

- 5.2% lower hospital charges;
- a 12% decrease in average length of stay; and
- a slight reduction in complication rates.[3]

The ability to generalize from this experience is limited by several factors. The payment reform was limited to only one type of procedure, and the evaluation period was short (the first six months after implementation). In addition, GHS is different from most health care systems because it is a large integrated system that includes a health plan and has a sophisticated electronic medical record system.

Example 2: Medicare Participating Heart Bypass Center Demonstration

This Medicare demonstration project involved bundling of all Medicare Part A and Part B services into a single payment rate for CABG surgery for an episode of care, including readmissions. It took place between 1991 and 1996 and involved patients treated at seven hospitals. Hospitals and physicians involved in the demonstration could divide the global payment in any way they chose.

This demonstration is one of the only examples of payment reform involving bundling where an evaluation of the impact over a long period of time is available. All participating hospitals exhibited declines in lengths of inpatient stay; Medicare saved $42.3 million on patients treated in demonstration hospitals (or approximately 10% of expected spending on CABG patients). In addition, participating hospitals experienced a decline in mortality rates, improved patient satisfaction, and patients saw fewer physicians.[4] As with the GHS example, generalizability of the results of this demonstration is limited by the fact that it only involved one type of treatment.

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[1] Abelson, R. "In Bid for Better Hospital Care, Heart Surgery With a Warranty." *The New York Times,* May 17, 2007.
[2] Lee T. "Pay for Performance, Version 2.0?" *New England Journal of Medicine,* August 9, 2007, p. 531-533.
[3] Casale AS, Bothe A, Jr., Paulus R, Selna M, McKinley K, Doll MC, Berry SA, and GD Steele. "ProvenCare, A Provider Driven Pay for Performance Program for Acute Episodic Cardiac Surgical Care." Geisinger Health System, Danville, PA. (abstract submitted for the 2007 American Surgical Association Annual Meeting.) http://www.americansurgical.info/abstracts/2007/20.cgi
[4] Cromwell J, Dayhoff D, McCall N, Subramanian S, Freitas R and R Hart; "Medicare Participating Heart Bypass Center Demonstration" Health Economics Research Inc., July 24, 1998.

Care Coordination and Management

Care coordination models of payment reform are intended to promote greater use of prevention and primary care services, with the goal of saving money by preventing the need for more expensive services and interventions in the future. These models are considered a type of payment reform because they would establish ways of paying providers for services that are not explicitly reimbursed under current payment systems. Examples of the types of services that are included in this type of payment reform include patient education, support and monitoring services (e.g., nurse phone contact with patients), payment for coordination of care among different providers who may be involved in caring for a patient, or implementation of a medical home model of care.

Current fee for service payment systems have few incentives for communication and coordination across providers. As noted earlier, the system rewards volume and so provider actions that improve care coordination (and reduce volume of services) can actually end up harming the provider financially.

Example 1: Medicare Coordinated Care Demonstration

In 2002, Medicare selected 15 sites to participate in its Coordinated Care Demonstration project. The program was designed to test the impact of care coordination models on patient satisfaction, health outcomes, and Medicare spending. The demonstration involved Medicare beneficiaries with complex chronic conditions, and outcomes and costs for patients receiving care coordination services were compared to randomly selected control groups of people with similar conditions. Care coordination providers in the 15 projects (these included commercial disease management companies, hospitals, academic medical centers, an integrated delivery system, and other entities) were paid a negotiated monthly fee per patient for their services, which ranged from $50 to $437, depending on the severity of the patient's illness.

According to a formal evaluation of the first two years of the project,[5] only 1 of the 15 sites showed a statistically significant reduction in hospitalizations, and there were no differences in spending for people in the care coordination program vs. the control group. People enrolled in the care coordination program were largely satisfied with it, and were more likely to report that they received health education materials; however, there were no clear effects of the program on patients' adherence to self-care guidelines.

Characteristics of the more successful care coordination programs included:

- Hiring well trained registered nurses as care coordinators;
- Conducting a large share of the contacts in person; and
- Focusing on improving the communication between doctors and patients.

[5] Mathematica Policy Research, "Second Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration," December 15, 2006.

In this evaluation, extensive use of information technology and electronic medical records were not found to be associated with better quality or cost performance.

The evaluation of this program notes that the relatively small numbers of people enrolled in the programs makes it difficult to find statistically significant effects, and also that 2 years may be too short a time period for the effects to become apparent (the demonstration was for a 4-year period). More research is needed to fully understand the impact of care coordination on costs and to identify the most effective program designs.

Example 2: Medical Home

The medical home model is built around the idea that patients benefit from having one physician who is actively engaged in coordinating all of their health care. The medical home concept is focused on improving communication between patients and *all* of their health care providers through the use of one coordinating physician.

We were unable to find many published studies that directly estimated the cost savings of medical homes. However, a study in Boston, Massachusetts evaluated the impact of a medical home model on 150 children with special health care needs. This study found that implementing a medical home model improved patient and family satisfaction with care, reduced hospitalizations by 15 percentage points, and was fairly low cost (around $400 per child per year).[6]

Although it is not a direct example of implementing a medical home model, recent experience from the Mayo Clinic has also been used to illustrate the potential impact of changes in incentives that encourage greater reliance on primary care.[7] In 2004, the Mayo Clinic changed the benefit set provided in its employee health plan to provide enrollees with financial incentives to use primary care rather than specialty care (by requiring a copayment for specialty care physician visits but not for primary care physician visits).

In the two years following this change, there was a reduction in hospitalizations, specialty care visits, and diagnostic testing, while the number of primary care visits increased. Total and per capita expenditures declined by about 10 percent.

By one estimate, if implementing this model throughout the state achieved a similar impact (10% per capita cost reduction), it could result in savings of around $2.8 billion per year. However, it is important to note that this is merely an illustration of the *potential* for savings associated with increased reliance on primary care versus specialty care, and not an estimate of the net savings associated with payment reform involving medical homes. The example described above involved a large employer providing a

[6] Palfrey JS, Sofis LA, Davidson EJ, Liu J, Freeman L, Ganz ML, "The Pediatric Alliance for Coordinated Care: Evaluation of a Medical Home Model," *Pediatrics*, May 2004, vol 113 (5 Suppl), p. 1507-16.
[7] George Schoephoerster, and Douglas L. Wood, "Patient-Centered Medical Home," Presentation to the Health Care Access Commission Workgroup on Identifying Health Care Costs/Savings, August 14, 2007.

very generous insurance benefit set, which is likely not typical of the benefit sets available to most Minnesotans.

Promoting Efficiency Through Shared Savings and Integrated Care

Sharing savings is another approach to encouraging cost effective, well-coordinated care. Medicare's Physician Group Practice Demonstration and recent reforms at the Virginia Mason Medical Center provide two examples of how the shared savings model can be used to encourage investment in care coordination and quality improvement.

Example 1: Physician Group Practice Demonstration

Ten large, multi-specialty physician group practices agreed to participate in this 3-year demonstration, which started April 1, 2005. The 10 groups represent 5,000 physicians and over 220,000 Medicare beneficiaries.

In this demonstration, Medicare beneficiaries are assigned to the physician group that has provided most of their care in the past. Physician practices are responsible for improving quality and containing costs for all of the beneficiaries assigned to them. The practices are eligible for performance payments *if the growth in Medicare spending for their assigned populations is more than 2 percentage points lower than the growth rate of Medicare spending in their local markets.* The demonstration provides an incentive for the practices to invest in care coordination and quality improvement infrastructure in order to generate savings and receive bonuses.[8]

Physician practices employed a variety of strategies to improve quality and lower costs including chronic disease management programs targeted at high cost beneficiaries, use of patient registries, use of electronic decision support to encourage evidence-based care, modifying physician work processes to improve coordination and avoid overtreatment, and enhanced discharge planning to avoid readmissions.

All of the practices participating in the demonstration met or exceeded the quality standards for diabetes; practices will be evaluated on the quality of preventive, coronary artery disease, and congestive heart failure care in future years. Only two practices qualified for bonuses under the savings criteria. Despite this, most participating practices felt that the investments in patient care were worthwhile even without the bonuses.

Example 2: Virginia Mason Medical Center

Virginia Mason Medical Center (VMMC) is a non-profit, integrated delivery system located in Seattle. VMMC undertook cost reduction and care improvement efforts after Aetna, a major insurer in the region, threatened to exclude VMMC from its high performance network. VMMC, Aetna, and employers worked together to improve efficiency of care for four common conditions: low back pain, gastroesophogeal reflux

[8] Physician Groups Improve Quality and Generate Savings Under Medicare Physician Pay for Performance Demonstration, press release from the Centers for Medicare and Medicaid Services, July 11, 2007

disease (GERD), migraines, and cardiac arrhythmia.[9] VMMC restructured patient traffic and decreased use of expensive diagnostic testing and name-brand medications.

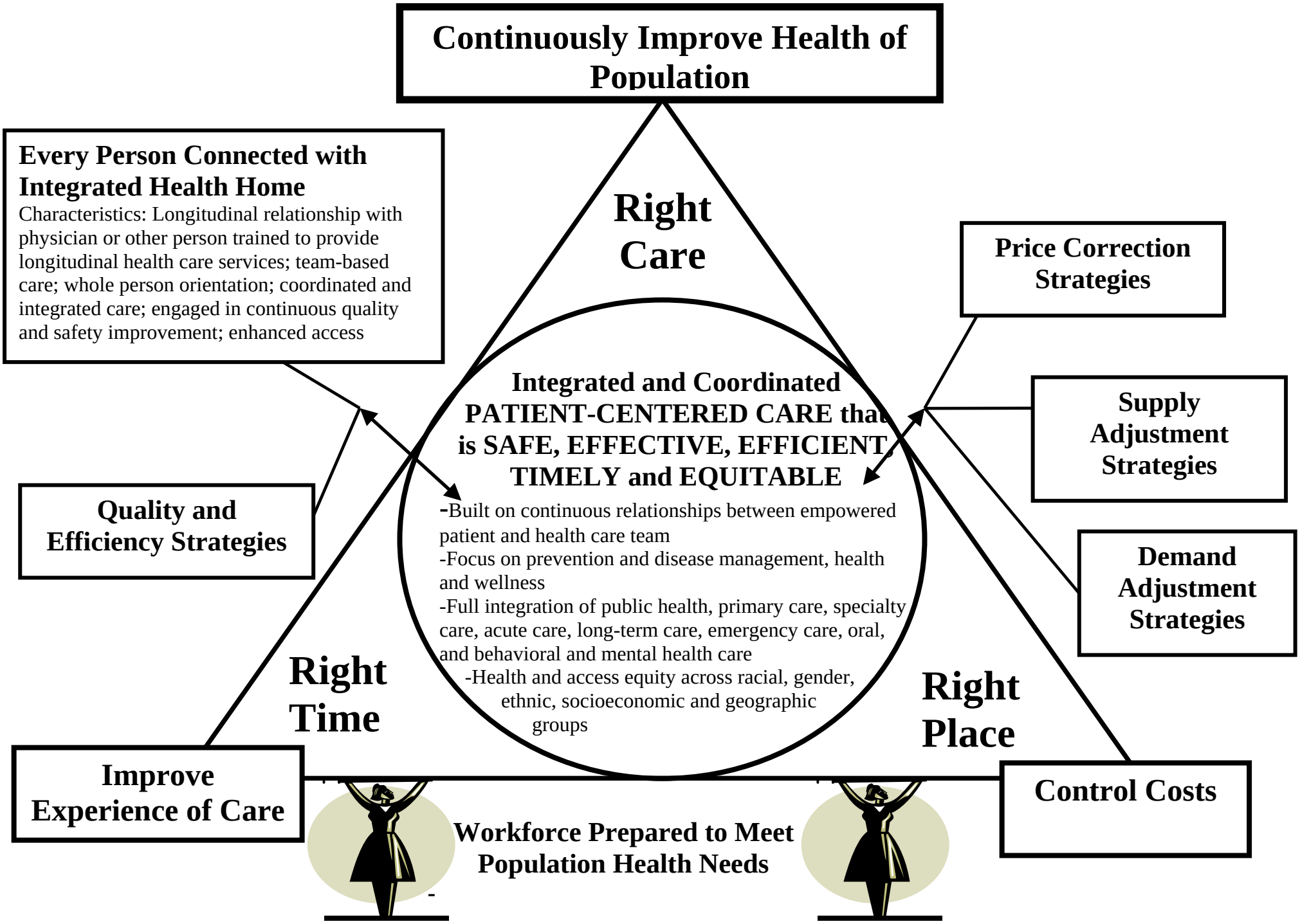
Preliminary findings showed significant savings. For example, VMMC was able to reduce its costs for treating low back pain by 11%. This savings was achieved by eliminating unnecessary MRIs and treating patients with lower cost services, such as physical therapy. However, the reduction in MRI use (which is a high profit service) resulted in a financial loss for VMMC. VMMC resolved this problem by appealing to employers, who encouraged Aetna to increase its reimbursement rates for physical therapy by 16%.[10]

The ability to generalize from this approach is somewhat limited by VMMC's status as an integrated delivery system and by the unusually high level of cooperation between providers, health plans, and employers. Also, the intervention involved four conditions that did not account for a very large share of VMMC's revenues. However, it provides a useful example of how current payment systems discourage efficiency improvements and how a shared savings model could be used to encourage more efficient care.

[9] Pham, H.; Ginsburg, P.; McKenzie, K.; and Milstein, A. "Redesigning Care Delivery in Response to a High-Performance Network: The Virginia Mason Medical Center." *Health Affairs* web exclusive, July 10, 2007.

[10] Fuhrmans, V. "A Novel Plan Helps Hospital Wean Itself Off Pricey Tests." *The Wall Street Journal*, January 12, 2007.

Framework for Delivery System Reform in Oregon
DRAFT 2/21/08



Excepts from Reports Consulted in Developing Framework for Delivery System Reform

Institute of Medicine (IOM)– Crossing the Quality Chasm
http://books.nap.edu/openbook.php?record_id=10027&page=R1

The committee proposes six aims for improvement to address key dimensions in which today's health care system functions at far lower levels than it can and should. Health care should be:

- Safe - avoiding injuries to patients from the care that is intended to help them.
- Effective - providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centered - providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely - reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient - avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Institute for Healthcare Improvement (IHI) – Best Health Care Results for the Population: The Triple Aim
http://www.ihi.org/NR/rdonlyres/5FFFC58F-3236-4FB7-8C38-2F07CC332AE3/0/IHITripleAimTechnicalBriefJune2007.pdf

Transformation of health care delivery starts with a transformational aim. The Institute for Healthcare Improvement believes that one such transformational aim includes a balance or optimization of performance on three dimensions of care—which IHI calls the "Triple Aim":

1. The health of a defined population;
2. The experience of care by the people in this population; and
3. The cost per capita of providing care for this population.

These three dimensions of care pull on the health care system from different directions. Changing any one of the three has consequences for the other two, either in the same or opposite directions. For example, improving health can raise costs; reducing costs can create poor outcomes, poor experience of care, or both; and patients' experience of care can improve without improving health. With the goal of optimizing performance on all three dimensions of care, we recognize the dynamics of each dimension while seeking the intersection of best performance on all three.

2006 Executive Order 13410: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs – Four Cornerstones
http://www.hhs.gov/valuedriven/fourcornerstones/index.html

The Executive Order is intended to ensure that health care programs administered or sponsored by the federal government build on collaborative efforts to promote four cornerstones for health care improvement:

1. **Interoperable Health Information Technology (Health IT Standards):** Interoperable health information technology has the potential to create greater efficiency in health care delivery. Significant progress has been made to develop standards that enable health information systems to communicate and exchange data quickly and securely to protect patient privacy. Additional standards must be developed and all health care systems and products should meet these standards as they are acquired or upgraded.
2. **Measure and Publish Quality Information (Quality Standards):** To make confident decisions about their health care providers and treatment options, consumers need quality of care information. Similarly, this information is important to providers who are interested in improving the quality of care they deliver. Quality measurement should be based on measures that are developed through consensus-based processes involving all stakeholders, such as the processes used by the AQA (multi-stakeholder group focused on physician quality measurement) and the Hospital Quality Alliance.
3. **Measure and Publish Price Information (Price Standards):** To make confident decisions about their health care providers and treatment options, consumers also need price information. Efforts are underway to develop uniform approaches to measuring and reporting price information for the benefit of consumers. In addition, strategies are being developed to measure the overall cost of services for common episodes of care and the treatment of common chronic diseases.
4. **Promote Quality and Efficiency of Care (Incentives):** All parties - providers, patients, insurance plans, and payers - should participate in arrangements that reward both those who offer and those who purchase high-quality, competitively-priced health care. Such arrangements may include implementation of pay-for-performance methods of reimbursement for providers or the offering of consumer-directed health plan products, such as account-based plans for enrollees in employer-sponsored health benefit plans.

Oregon Health Fund Board Delivery Systems Committee
Cost Containment Strategies
FOR DISCUSSION ONLY 2/21/08

Goal: Adjust Supply of Care Through Incentives to Encourage Provision of Effective and Efficient Care

Strategy	Possible Approaches	Target
Targeted Capital Investment	Redesign certificate of need or establish alternative program to effectively control costs, reduce duplicative services and encourage investments in primary care	Providers
	Creation of centers of excellence program	Providers
	Pilot regional health planning organizations	Providers and Communities
Comparative Effectiveness/Medical Technology Assessment	Create collaboration around evaluation of new devises, drugs, procedures and other treatments for comparative effectiveness through expanded role for state's HRC/HSC or through a new entity	All
	Develop and/or endorse clinical guidelines for OHFP providers and widespread statewide adoption	Providers
	Require OHFP plans to design benefits from evidence of added value of treatments and procedures and consistently update using new information	Health Plans
	Pilot projects that require private and public purchasers and health plans to collaborate around joint policies regarding coverage of new technologies and procedures	Health Plans, Purchasers
Provider Payment Strategies Focused on Integrated Health Home (most likely a combination of approaches will be needed)	Bundled per member per month prospective payments for providing integrated health home services (risk adjusted)	Providers
	Capitated payment to integrated health homes to provide all primary care and disease management services (tied to clinical guidelines, risk-adjusted)	
	Pay for Process - Reward providers for providing integrated health home services	
	Pay for Performance - Reward providers for better health outcomes, higher quality and more efficient use of resources	

Goal: Adjust Supply of Care Through Incentives to Encourage Provision of Effective and Efficient Care (Continued)

Strategy	Possible Approaches	Target
Provider Payment Strategies to be Applied to Integrated Health Homes and Across Wider Delivery System	Bundled payments based on episodes of care or portion of episodes of care	Providers
	Condition specific capitation	
	Performance payments for practices able to meet quality goals	
Hospital payments	Hospital pay for performance with bonus payments based on top performance, absolute performance and/or performance improvement	Hospitals

Long-Term or Short-Term
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Long-Term
Long-Term
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Long-Term or Short-Term
Long-Term
Long-Term

Oregon Health Fund Board
Delivery Systems Committee
Companion to Cost Containment Strategies Matrix
DRAFT FOR DISCISSION ONLY 2/21/08

The following document is meant to provides examples of cost containment initiatives that have been proposed and implemented in Oregon and across the nation, but does not provide an exhaustive list of such efforts.

Overall Goals

GOAL: Improve Quality and Efficiency of Care Provided Across Oregon

Strategy 1: Paying for Quality

Possible Approaches:

A. Competitive Contracting/Value-Based Purchasing For All Publicly Purchased Health Care
- Target: Purchasers
- Time Frame: Long-Term Savings

Related Proposals and Efforts in Oregon
- Oregon Public Employees Benefits Board and Oregon Educators Benefits Board have built quality requirements into contracts with plans providing benefits to state employees and K-12 school district employees.

B. No Billing for National Quality Forum "Never Events" (28 adverse events that are largely preventable)
- Target: Health Plans, Providers
- Time Frame: Long-Term Savings

Related Proposals and Efforts in Oregon
- 2007 Legislation established the Health Care Acquired Infection Advisory Committee to advise the Office for Oregon Health Policy and Research on the development of mandatory reporting program for hospital inquired infections to start in January 2009.

Examples of Related State and National Proposals and Implemented Initiatives

- Starting in October 2008, CMS will stop paying for added costs of eight hospital acquired conditions (five of which are NQF "never events").[1]
- In September 2007, the Governor of Minnesota announced a statewide policy, created by the Minnesota Hospital Association and Minnesota Council of Health Plans and endorsed by the Governor's Health Care Cabinet, which prohibits hospitals from billing insurance companies and others for care associated with never events.[2]
- Minnesota's Health Care Transformation Task Force recommended that health plans and providers should contribute financially to fund provider collaboratives, which would set minimum standards/expectations for outcomes of care. The Task Force recommended that purchasers and payers refuse to pay for care that doesn't meet these standards (Recommendation II-A4 and II-A5).[3]
- Pennsylvania Employees Benefit Trust Fund recently announced plans to stop paying for "never events."[4]

Strategy 2: Improved Quality and Transparency

Committee to receive recommendations for Quality Institute Workgroup in 3/08

Strategy 3: Health Information Technology

Committee to receive recommendations from HIIAC

Goal: Correct Health Care Price Signals

Strategy 1: Uniform Payment Rates

Possible Approaches:

A. Uniform Payment Rates for Hospitals and/or All Providers Based on % Medicare Rates
    - Target: Providers, Payers
    - Time Frame: One-Time Savings

    Examples of Related State and National Proposals and Implemented Initiatives
    - The Commonwealth Fund recommends All-Payer Provider Payment Methods and Rates (Bending the Curve Recommendation 14).[5]
    - Maryland's Health Services Cost Review Commission (HSCRC) sets uniform rates for hospital payments for all payers in the state, including private insurance companies, HMOs, Medicare, and Medicaid. This all-payer system has saved the state significant money in hospital costs by keeping growth in cost per admission below the national average.[6]
    - The Minnesota Health Care Transformation Task Force recommended that all providers should establish and make publicly available a single price for each service billed on a free for service of offered under a "basket of care" (a collection of individual services that are currently paid separately under the fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient) (Recommendation III-B2).[7]

Strategy 2: Reduce Administrative Spending

A. Encourage Health Insurers and/or Purchasers to Adopt Common Forms and Procedures for Enrollment and Building Across All Payers, Matching Medicare Requirements as Close as Possible
    - Target: Health Plans, Purchasers, Providers
    - Time Frame: ??

    Examples of Related State and National Proposals and Implemented Initiatives
    - The Health Insurance Portability and Minnesota Health Care Administrative Simplification Act of 1994 was passed to create greater standardization of health care administrative transactions and more electronic exchange of administrative data in an effort to reduce administrative costs and burden. 2007 changes to the Act will require three administrative transactions, including eligibility verification, health care claims and payment and remittance advice, to be exchanged electronically using a single standard for content and format. These standards apply to all providers and payers.[8]

- The Minnesota Health Care Transformation Task Force recommended administrative requirements by state and national licensing organizations be streamlined and coordinated and that simpler, lower-cost methods of collecting payments from consumers should be developed in order to reduce provider administrative and bad debt collection costs (Recommendation IV-B2 and IV-B3).[9]
- Colorado's Blue Ribbon Commission recommends requiring health insurers and encouraging all payers to use standard claims attachment requirements, eligibility and coverage verification systems, electric ID cards, prior authorization procedures, and uniform insurance application forms (Recommendation 3a).[10]

Strategy 3: Health Plan Regulation

A. Set Minimum Loss Ratio (% of premium dollars that must be spent on medical care)
    - Target: Health Plans
    - Time Frame: ??

    Examples of Related State and National Proposals and Implemented Initiatives
    - New Jersey requires insurers to file a certification that medical claims will exceed 75% of premiums. If at the end of the year, an insurer that has spent less than 75% of collected premiums on medical claims is required to issue refunds to enrollees for the difference.[11]
    - Under Maine's Dirigo Health Reform, medical loss ratio is set at 78%.[12]

B. Cap Administrative Costs and Profits/Net Income of Insurance Providers
    - Target: Health Plans
    - Time Frame: ??

C. Add Investment Income and Insurer Profits as Key Factors to be Reported and Considered in Rate Approval Process
    - Target: Health Plans
    - Time Frame: ??

    Related Proposals and Efforts in Oregon
    - The Department of Consumer and Business Services recommended that health plans be required to report investment income and insurer profits and that these factors should be considered in the rate approval process (Health Insurance in Oregon Recommendation 1).[13]

D. Increase Transparency by Defining Insurance Rate Filings as Public Records Open to Public Scrutiny
    - Target: Health Plans
    - Time Frame: ??

Related Proposals and Efforts in Oregon

- The Department of Consumer and Business Services (DCBS) recommended a more transparent rate and public rate filing process, including posting of health insurance rate filings on the DCBS website (Health Insurance in Oregon Recommendation 2).[14]

Examples of Related State and National Proposals and Implemented Initiatives

- Michigan has defined rate filing as public records open to public scrutiny.[15]

E. Expand Scope of Insurance Rate Review to Larger Groups
   - Target: Health Plans
   - Time Frame: ??

   Related Proposals and Efforts in Oregon
   - The Department of Consumer and Business Services recommended that the rate regulation process currently used for groups with up to 25 employees be extended to groups with 26-50 employees (Health Insurance in Oregon Recommendation 4).[16]

Strategy 4: Hospital Regulation

A. Limit Profits/Net Income of Hospitals
   - Target: Health Plans
   - Time Frame: ??

Strategy 5: Reduced Spending on Pharmaceuticals

A. Negotiated Drug Prices for all OHFP Participants
   - Target: Pharmaceutical Companies
   - Time Frame: One-Time Savings

   Related Proposals and Efforts in Oregon
   - The Oregon Prescription Drug Purchasing (OPDP) Program is a prescription drug purchasing pool established in 2003 to help increase access to prescription drugs by the uninsured and lower costs for state and city governments by pooling drug purchasing power, using evidence-based research to develop a preferred drug list of lowest cost drugs, negotiating competitive discounts with pharmacies and bringing transparent pharmacy benefit management services to groups. All Oregonians who are uninsured or underinsured for prescription drugs are eligible to participate. In February 2007, OPDP joined the Washington Prescription Drug Program to form the Northwest Prescription Drug Consortium.

Examples of Related State and National Proposals and Implemented Initiatives

- The Veterans Administration and Department of Defense combine purchasing power to buy pharmaceuticals. The VA also reduces spending on pharmaceuticals by using a formulary that emphasizes the use of generic and low-cost drugs and uses a highly automated mail order system that dispenses more than three-quarters of all VA prescriptions.[17]
- The National Medicaid Pooling Initiative (NMPI) allows participating state Medicaid programs to "pool" their covered Medicaid lives as negotiating leverage to acquire greater supplemental rebates from pharmaceutical manufacturers. NMPI currently includes the Medicaid programs from 10 states: Alaska, Hawaii, Kentucky, Michigan, Minnesota, Montana, Nevada, New Hampshire, New York and Tennessee.[18]

GOAL: Adjust Demand for Care by Encouraging Healthy Behaviors and Informed Decision Making

Strategy 1: Public Health Strategies

Possible Approaches:

A. Fund Public Health Activities with Evidence of Positive Outcomes
    - Target: Consumers
    - Time Frame: Long-Term Savings

    Examples of Related State and National Proposals and Implemented Initiatives
    - The U.S. Preventive Services Task Force and the Community Task Force have recommended evidence-based preventative strategies in clinical and community settings for tobacco use and obesity.[19]
    - Colorado Blue Ribbon Commission recommended increased funding for public health agencies in Colorado to perform disease and injury prevention programs, assessing community health and promoting healthy behavior (Recommendation 4e).[20]

Strategy 2: Health Plan Design

Possible Approaches:

A. Support Plan Design that Encourages Healthy Behaviors, Prevention and Disease Management
    - Target: Consumers
    - Time Frame: Long-Term Savings

    Examples of Related State and National Proposals and Implemented Initiatives
    - The Commonwealth Fund recommends state and private employers design benefits that provide incentives for healthy behaviors and participation in disease management programs, allow employees to use flexible spending accounts for programs to control weight and quit smoking and exempt preventative services recommended by the U.S. Preventative Services Task Force from deductibles (Bending the Curve Recommendation 6).[21]
    - Colorado's Blue Ribbon Commission recommended reduced premiums for enrollees who engage in healthy behaviors (Recommendation 4a).[22]
    - Colorado's Blue Ribbon Commission recommended that individuals be encouraged to take individual responsibility for health, wellness and preventative behavior by incentivizing consumers to engage in healthy behaviors and use appropriate preventative care (Recommendation 4d).[23]
    - Maine's Dirigo Health Program offers premium discounts for individuals who do not smoke.[24]
    - West Virginia's Medicaid program requires enrollees to sign a statement of member responsibilities and rights, in which they agree to take their

medications, keep their appointments, participated in health screenings and adhere to improvement programs as directed by their providers, and avoid unnecessary emergency room visits. Patients who don't fulfill their obligations face some reduced or eliminated benefits.[25]

B. Explore No/Reduced Copays for Preventative Services
    - Target: Consumers
    - Time Frame: Long-Term Savings

    Examples of Related State and National Proposals and Implemented Initiatives
    - In Vermont's Catamount Health program, preventative care for all enrollees and chronic care for patients enrolled in Catamount's Chronic Care Management Program is not subject to cost sharing.[26]
    - Colorado's Blue Ribbon Commission recommends elimination of patient copayments for preventative care and reduced patient copayments for chronic care management services (Recommendation 4b).[27]

C. Increased Cost-sharing for Treatment Options Found to be Inconsistent with Clinical Guidelines
    - Target: Consumers
    - Time Frame: Long-Term Savings

    Examples of Related State and National Proposals and Implemented Initiatives
    - Health economists Fendick and his colleagues have proposed value-based insurance design which has two general approaches: 1) targets services known to be of high value with lower copays; 2) targets patients with select clinical diagnoses and lowers copays for specific high-value services. The University of Michigan has implemented a value-base insurance design for employees with diabetes.[28]
    - The Commonwealth Fund recommends increased copays for treatment options that are found to be inconsistent with appropriate management of chronic illness (Bending the Curve Recommendation 1).[29]
    - The Minnesota Health Care Transformation Task Force recommended that consumers incur lower costs for using more cost-effective, higher-quality providers (Recommendation III-C).[30]

<u>Strategy 3: Creating a Culture of Health</u>

Possible Approaches:

A. Encourage Employers, Schools and Community Organizations to Build a Culture of Health and Encourage Activities that Reduce Absenteeism, Decrease Disability Rates and Increase Productivity
    - Target: Consumers, Communities
    - Time Frame: Long-Term Savings

Related Efforts and Proposals in Oregon

- Regence Blue Cross Blue Shield has made significant efforts to create a culture of wellness in the workplace and help employees live healthy lives. Regence maintains Club Blue fitness centers at its facilities, where employees can use exercise equipment or take a fitness class, provides health coaches, who are available to help employees who want to adopt healthy behaviors such as weight loss or smoking cessation, and offers employees a 35% discount for healthy options at their on-site cafeterias.
- OHSU has a tobacco-free policy at all its Portland area properties. To help tobacco users comply with the policy, OHSU has arranged free counseling, prescriptions and over the counter medication for staff and students interested in quitting and managing cravings. Visitors to the campus or medical centers have access to free nicotine replacement lozenges.
- HB 2650 passed during the 2007 Legislative session sets health standards for foods sold in Oregon's public schools.

Examples of Related State and National Proposals and Implemented Initiatives

- In 2002, legislation was passed in Arkansas that established the Arkansas School BMI Assessment Project. The BMI by age of every child in K-12 is annually measured and sent to parents in a health report, which includes suggestions for changing diet and activity patterns for overweight children.[31]
- Colorado's Blue Ribbon Commission recommended employers be encouraged to provide workplace wellness programs for employees (Recommendation 4c).[32]
- Maine's Dirigo Health program provides premium discounts to small and large businesses that provide approved worksite wellness programs.[33]
- Minnesota's Health Care Transformation Task Force recommended aggressive goals for the reduction of obesity, tobacco use, alcohol abuse and drug addictions that should be priorities for the state as a whole and for employers, schools, communities and the health care system in order to prevent chronic disease and other health problems (Recommendation I-A). This recommendation included development of recommendations regarding the frequency with which Minnesotans should complete health risk assessments and development of a system to measure body mass index of children.[34]
- The Minnesota Legislative Commission Health Care Access recommended the state adopt in statute statewide curriculum standards for health nutrition and physical education, as requirements for graduation (Recommendation 1.2).[35]

B. Build Culture of Health for State Employees
    - Target: State Employees
    - Time Frame: Long-Term Savings

Examples of Related State and National Proposals and Implemented Initiatives

- The Minnesota Health Care Transformation Task Force specifically recommended that the state should be responsible for achieving goals for priority health conditions and diseases for state employees. (Recommendation I-A7).[36]

Strategy 4: Shared Decision Making

Possible Approaches:

A. Encourage Use of Patient Decision Aids Before Having Certain Preference Sensitive Procedures Where Have Been Shown to Increase Use of Cost-effective Interventions
   - Target: Providers, Consumers
   - Time Frame: Long-Term Savings

   Examples of Related State and National Proposals and Implemented Initiatives
   - The Commonwealth Fund, recognizing the work of the Dartmouth Atlas of Health Care (www.dartmouthatlas.org) demonstrating the unwarranted variation in the use of medical resources across the country, recommends that CMS require fee-for-service Medicare beneficiaries to use patient decision aids for high-cost preference-sensitive procedures, where they have been shown to increase the use of cost-effective interventions (Bending the Curve Recommendation 2).[37]
   - In 2007, the Washington Legislature passed SB 5930 related to shared decision making in several ways: 1) the Legislature formally acknowledged shared decision making and the benefit of using decision aids for the first time by a state legislature; 2) the bill established a demonstration project to evaluate the implications of incorporating shared decision making and the use of decision aids into everyday practice; and 3) the bill provides legal protection to physicians who choose to engage in Shared Decision Making with their patients.
   - The Minnesota Health Care Transformation Task Force recommended that providers should engage patients in decision-making about care and that information about treatment options should be provided by someone without financial interest in the patient's choice. The Task Force recommended that if necessary, legislation should be considered to provide appropriate liability protection for providers using shared-decision –making with patients (Recommendation II-A6).[38]

GOAL: Adjust Supply of Care Through Incentives to Encourage Provision of Effective and Efficient Care

Strategy 1: Targeted Capitol Investments

Possible Approaches:

A. Redesign Certificate of Need or Establish Alternative Program to Effectively Control Costs, Reduce Duplicative Services and Encourage Investments in Primary Care
    - Target: Providers
    - Time Frame: Long-Term Savings

B. Creation of Centers of Excellence Program
    - Target: Providers
    - Time Frame: Long-Term Savings

C. Pilot Regional Health Planning Organizations
    - Target: Providers, Communities
    - Time Frame: Long-Term Savings

    Examples of Related State and National Proposals and Implemented Initiatives
    - Elliot Fisher, et al. at Dartmouth Medical School have developed a model of organizing physicians and hospitals nationwide into accountable care organizations, which publicly report their outcomes and costs**.** Fisher proposes that accountable care organizations can help establish accountability for local decisions about capacity and that measuring quality and cost at the hospital staff level could help pinpoint examples of overuse of services that would not otherwise be identified.[39]

Strategy 2: Comparative Effectiveness/Medical Technology Assessment

Possible Approaches:

A. Create Collaboration Around Evaluation of New Devises, Drugs, Procedures and Other Treatments for Comparative Effectiveness Through Expanded Role for State's Health Resources Commission/Health Services Commission or Through a New Entity
    - Target: All
    - Time Frame: Long-Term Savings

    Related Proposals and Efforts in Oregon
    - The Health Resources Commission (HRC) was created as part of the Oregon Health Plan to encourage the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of

information concerning the effectiveness an cost of medical technologies and their impact on the health and health care of Oregonians. HRC is directed to conduct medical technology assessments program (MedTAP); serve as a statewide clearinghouse for medical technology information; monitor the use, costs and outcomes associated with selected medical technologies in Oregon, using available data; identify information which is needed but lacking for informed decision making regarding medical technology, and fostering mechanisms to address such deficiencies; provide a public forum for discussion and development of consensus regarding significant emerging issues related to medical technology; and inform health care decision makers, including consumers, of its findings and recommendations regarding trends, developments and issues related to medical technology.

- Oregon's Health Services Commission (HSC) is responsible for developing and maintaining the Prioritized List, which ranks health services based on the comparative benefits of each service to the entire population served. The Commission is directed to encourage effective and efficient medical evaluation and treatment by considering both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance. The Health Services Commission reported a new Prioritized List of Health Services for the 2007-09 biennium, which places a new emphasis on preventive care and chronic disease and also reflects a better account of clinical effectiveness and cost-effectiveness into the ranking of health services. The list is used to determine the services that are covered by the Oregon Health Plan.
- The Drug Effectiveness Review Project (DERP) is a collaboration of organizations that have joined together to obtain the best available evidence on effectiveness and safety comparisons between drugs in the same class, and to apply the information to public policy and decision making in local settings. DERP is funded by the Agency for Healthcare Research and Quality, along with participating organization and is based at Oregon's Center for Evidence-Based Policy at OHSU. The Oregon Evidence-Based Practice Center, also at OHSU, is a participating member in DERP, as are organizations from Arkansas, Idaho, Kansas, Michigan, Minnesota, Missouri, Montana, North Carolina, New York, Washington, Wisconsin and Wyoming and the Canadian Agency for Drugs and Technologies in Health.

Examples of Related State and National Proposals and Implemented Initiatives

- The VA's Technology Assessment Program (VATAP) is a national program within the Office of Patient Care Services dedicated to advancing evidence-based decision making in the VA (including the US Department of Veterans Affairs, Veterans Health Administration and the Office of Patient Care Services). VATAP carries out systematic reviews of the medical literature on "what works" in health care, promotes excellent health care value through evidence-based decision making, and provides

impartial, peer reviewed evidence-based reports to support better resource management in VHA.[40]

- The Technology Evaluation Center (TEC) of the Blue Cross/Blue Shield Association uses scientific criteria for assessing medical technologies through comprehensive reviews of clinical evidence. TEC completes 20-25 assessments a year, which are comprehensive evaluations of the clinical effectiveness and appropriateness of a given medical procedure, device or drug. TEC serves a wide range of clients in both the private and public sectors, including Kaiser Permanente and the Centers for Medicare and Medicaid Services (CMS).[41]
- The technology assessment program at the Agency for Healthcare Research and Quality (AHRQ) provides technology assessments for the Centers for Medicare & Medicaid Services (CMS). These technology assessments are used by CMS to inform its national coverage decisions for the Medicare program as well as provide information to Medicare carriers. AHRQ's technology assessment program uses state-of-the-art methodologies for assessing the clinical utility of medical interventions. Technology assessments are based on a systematic review of the literature, along with appropriate qualitative and quantitative methods of synthesizing data from multiple studies. AHRQ also contracts with state-based evidence-based practice centers to conduct other evidence-based reports and technology assessments.
- The Commonwealth Fund recommends the establishment of a Center for Medical Effectiveness and Health Care Decision-Making as a public/private partnership to identify information required make better medical decisions, collect information where it exists and generate the information where it does not (Bending the Curve Recommendation 1). The responsibilities of the Center would include providing targeted funding for research intended to evaluate existing and new devices, drugs, procedures and other treatment regimens that it identified as most important for improving overall appropriateness of health care and health care spending.[42]
- The Minnesota Health Care Transformation Task Force recommended the development of a collaborative, non-regulatory body to review new technologies, services, and medications and to recommend whether new services should covered by health insurance plans based on a method similar to the one utilized by Britain's National Institute for Health and Clinical Excellence (Recommendation IV-D).[43]

B. Develop and/or Endorse Clinical Guidelines for OHFP Providers and Widespread Statewide Adoption
    - Target: Providers
    - Time Frame: Long-Term Savings

Examples of Related State and National Proposals and Implemented Initiatives

- Colorado's Blue Ribbon Commission recommended adoption of population-specific guidelines and performance measures, where they exist, based on existing national, evidence-based guidelines and measures, recognizing the importance of patient safety and best care for each patient (Recommendation 10a).[44]
- The Puget Sound Health Alliance convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region. Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain. Teams currently developing asthma and prevention reports.[45]
- The Institute for Clinical Systems Improvement (ICSI) in Minnesota is an independent, non-profit organization that includes medical groups and hospital systems. ICSI produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota.[46]
- Minnesota's Health Care Transformation Task Force recommended that providers participate in collaboratives for improving patient outcomes through evidence-based processes and that providers should deliver care consistent with evidence-based guidelines (Recommendation II-A1 and II-A2).[47]
- Professional organizations, including the Clinical Efficacy Assessment Project of the American College of Physicians, the Joint Guidelines of the American College of Cardiology and American Health Association and the Committee on Gynecologic and Obstetric Practice of the American College of Obstetrics and Gynecology, develop clinical guidelines for widespread distribution.

C. Require OHFP Plans to Design Benefits from Evidence of Added Value of Treatments and Procedures and Consistently Update Using New Information

- Target: Health Plans
- Time Frame: Long-Term Savings

Related Proposals and Efforts in Oregon

- The benefit package covered by the Oregon Health Plan is determined using the Health Services Commission's Prioritized List of Health Services (see above).
- The Medicaid Evidence-based Decisions Project (MED), housed at OHSU, is a collaboration of state Medicaid programs for the purpose of making high quality evidence available to states to support benefit design and coverage decisions made by state programs. MED commissions and provides access to high quality systematic reviews of existing evidence,

technology assessments, a web based clearinghouse, support in designing rapid evaluations of products where no evidence exists and the support of staff to assist member state in applying evidence.

Examples of Related State and National Proposals and Implemented Initiatives

- The State of Washington's Health Technology Assessment Program was created in 2006 to ensure that health technologies purchased by the state are safe and effective and coverage decisions made by various state agencies are consistent, transparent and based on evidence.[48]

D. Pilot Projects That Require Private and Public Purchasers and Health Plans to Collaborate Around Joint Policies Regarding Coverage of New Technologies and Procedures
   - Target: Health Plans, Purchasers
   - Time Frame: Long-Term Savings

   Examples of Related State and National Proposals and Implemented Initiatives
   - The Minnesota Health Care Transformation Task Force proposed a series of recommendations regarding payment for technologies, services, and medications based on proven effectiveness and evidence-based science, including: 1) limiting payment to services proven to be effective; 2) convening providers, purchasers, and payers to develop and implement recommendation for reducing overutilization of services; 3) designing benefits based on the value of each service provided; 4) health insurance plans should only pay for care known to be effective (Recommendation IV-D).[49]

<u>Strategy 3: Provider Payment Strategies Focused on Integrated Health Home</u>

Possible Approaches (combination of approaches will likely be needed):

A. Bundles Per Member per Month Prospective Payments for Providing Integrated Health Home Services (Risk Adjusted)
   - Target: Providers
   - Time Frame: Long-Term Savings

B. Capitated Payment to Integrated Health Homes to Provide All Primary Care and Disease Management Services (Risk Adjusted)
   - Target: Providers
   - Time Frame: Long-Term Savings

C. Pay for Process – Reward Providers for Providing Integrated Health Home Services
   - Target: Providers
   - Time Frame: Long-Term Savings

D. Pay for Performance – Reward Providers for Better Health Outcomes, Higher Quality and More Efficient Use of Resources
    - Target: Providers
    - Time Frame: Long-Term Savings

Examples of Related National and State Payment Reform Proposals and Implemented Initiatives

- Colorado's Blue Ribbon Commission recommended that providers in public programs be reimbursed for providing care coordination and case management to their high-needs patients (Recommendation 8b).[50]
- The Patient-Centered Primary Care Collaborative has proposed a payment structure for practices qualified as advanced medical homes which includes a three part structure: 1) A prospective, bundled payment for overhead costs linked to the provision of medical home services and coordination component that recognizes the work value of physician and non-physician clinical and administrative care coordination component; 2) a visit-based fee-for service component that recognizes visit-based services that are currently paid; and 3) a performance-based component.[51]
- Goroll, et al., have proposed payment reform for adult primary care that includes replacing encounter-based reimbursement with comprehensive payment for comprehensive care directed to practices to include support for the modern systems and teams essential to the delivery of comprehensive, coordinated care. With this model, income to primary physicians would be increased commensurate with the high level of responsibility expected. To ensure optimal allocation of resources and the rewarding of desired outcomes, the comprehensive payment is needs/risk-adjusted and performance-based.[52]
- The Minnesota Legislative Commission Health Care Access recommended that practices designated as health care homes should receive a per-person, per-month coordination fee for costs associated with providing health care home services that will not exceed an average of $50 per member per month. Specific payments would be determined on a sliding scale based on complexity of care needs for each individual (Recommendation 2.1 – Health Care Home/Care Coordination Fee).[53]

<u>Strategy 4: Provider Payment Strategies to Be Applied to Integrated Health Homes and Across Wider Delivery System</u>

Possible Approaches (combination of approaches will likely be needed):

A. Bundled Payments Based on Episodes of Care or Portion of Episodes of Care
    - Target: Providers
    - Time Frame: Long-Term Savings

B. Condition Specific Capitation
    - Target: Providers

- Time Frame: Long-Term Savings

C. Performance Payments for Practices Able to Meet Quality Goals
   - Target: Providers
   - Time Frame: Long-Term Savings

Examples of Related State and National Payment Reform Proposals and Implemented Initiatives

- The Commonwealth Fund recommends transition to payment system based on bundles payments for episodes of care (Bending the Curve Recommendation 8).[54]
- Colorado's Blue Ribbon Commission recommended payment for providers based on their use of care guidelines, performance on quality measures, coordination of patient care and use of health information technology (Recommendation 11a).[55]
- Minnesota's Health Care Transformation Task Force recommended a payment reform process with three stages to be implemented as providers are ready for each level. The levels of the proposal include: 1) Level 1 would involve payments to providers (including primary and specialty care providers, as well as hospitals) dependent on the quality and efficiency of care provided, using outcomes measures whenever possible; 2) Level 2 would involve case management fees for providers assuming greater responsibility for coordinating care for patients, particularly those with chronic conditions; and 3) Level 3 would involve providers and care systems assuming responsibility for the total cost of care provided for patients under a standardized benefit set (Recommendation III-A). The Task Force also recommended that fee levels for primary care, care management, and other cognitive services should be increased relative to other services, in a cost-neutral way (Recommendation III-B1).[56]
- The Prometheus Payment Model proposes the development of clinical practice guidelines for particular conditions, estimating the cost of delivering the care in the guideline and turning that into an evidence-based case rate to cover all of the care by all of the providers who will be involved in patient care. 10-20% of the amount would be withheld and used to pay providers based on performance.[57]
- Starting in 2006, the Geisinger Health System in Pennsylvania implemented a 90 day warranty for care provided to all non-emergency coronary bypass graft patients and began charging a single price for a bundle of services including hospitalization and all related care for a 90-day period, including any readmission for complications.[58]

Strategy 4: Hospital Payments

Possible Approaches:

A. Hospital Pay for Performance with Bonus Payments Based on Top Performance, Absolute Performance and/or Performance Improvement
   - Target: Hospitals
   - Time Frame: Long-Term

   Examples of Related State and National Proposals and Implemented Initiatives
   - The Commonwealth Fund recommends Medicare hospital pay-for-performance based on the CMS/Premiere Hospital Quality Incentives Demonstration for all acute-care hospitals that are paid under Medicare's prospective payment system. The base payments to hospitals would be reduced and the difference would be used to pay for bonus payments based on top performance, absoluter performance and performance improvement (Bending the Curve Recommendation 7).[59]

[1] M. Rosenthal. 2007. Nonpayment for Performance. The New England Journal of Medicine. 357(16): 1573-1575.
[2] Office of Governor of Minnesota. 2007. Press Release: First-in-the-nation Health Care Billing Policy Announced in Minnesota. Available: http://www.governor.state.mn.us/mediacenter/pressreleases/2007/PROD008314.html
[3] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008. http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf
[4] A. McKethan, T. Savela and W. Joines. 2008. What Public Employee Health Plans Can Do to Improve Health Care Quality: Examples from the States. The Commonwealth Fund.
[5] C. Schoen, et al. 2007. Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending. The Commonwealth Fund. Available: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=620087
[6] Health Services Cost Review Commission website. http://www.hscrc.state.md.us/about_hscrc/AboutHSCRC.htm.
[7] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[8] Minnesota Department of Health website. http://www.health.state.mn.us/asa/
[9] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[10] Blue Ribbon Commission for Health Care Reform. 2008. Final Report to the Colorado General Assembly. Available: http://www.colorado.gov/cs/Satellite?c=Page&cid=1201542097631&pagename=BlueRibbon%2FRIBBLayout
[11] Familes USA. 2006. Issue Brief: Understanding How Health Insurance Premiums are Regulated. Available:
[12] M. Trinity, et al. 2008. State of the States. Robert Wood Johnson State Coverage Initiatives. http://statecoverage.net/pdf/StateofStates2008.pdf
[13] Oregon Department of Consumer and Business Services. 2007. Health Insurance in Oregon. Available: http://www.cbs.state.or.us/external/ins/health_report/health-report_intro.html.
[14] Department of Consumer and Business Services. 2007.

[15] Department of Consumer and Business Services. 2007.
[16] Department of Consumer and Business Services. 2007.
[17] American College of Physicians. 2008. Achieving a High Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries. Annals of Internal Medicine. 148:55-75.
[18] National Conference of State Legislators. 2007. Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans, 2007 edition. Available http://www.ncsl.org/programs/health/bulkrx.htm
[19] J. Ockene, et al. 2007. Integrating Evidence-Based Clinical and Community Strategies to Improve Health. American Journal of Preventative Medicine. 32(3): 244-252.
[20] Blue Ribbon Commission for Health Care Reform. 2008.
[21] C. Schoen, et al. 2007.
[22] Blue Ribbon Commission for Health Care Reform. 2008.
[23] Blue Ribbon Commission for Health Care Reform. 2008.
[24] M. Trinity, et al. 2008.
[25] G. Bishop and A. Brodkey. Personal Responsibility and Physician Responsibility – West Virginia's Medicaid Plan. 355(8):756-758.
[26] H. Olsen. 2006. Catamount Health: Vermont's Health Care Reform Plan. Available http://www.une.edu/com/chppr/pdf/catamounthealth_olson.pdf.
[27] Blue Ribbon Commission for Health Care Reform. 2008.
[28] M. Frendrick and M. Chernew. 2006. Value-based Insurance Design: Aligning Incentives to Bridge the Divide Between Quality Improvement and Cost Containment. The American Journal of Managed Care. 12: SP5-SSP10.
[29] C. Schoen, et al. 2007.
[30] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[31] Arkansas Center for Health Improvement website. Current Initiatives: Body Mass Index Initiative. http://www.achi.net/current_initiatives/BMI_Info/bmi.asp
[32] Blue Ribbon Commission for Health Care Reform. 2008.
[33] M. Trinity, et al. 2008.
[34] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[35] The Legislative Commission on Health Care Access. 2008. Final Report: Recommendations Submitted to the Minnesota State Legislature.
http://www.commissions.leg.state.mn.us/lchca/HCAC%20Report%20final%202-08.pdf
[36] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[37] C. Schoen, et al. 2007.
[38] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008
[39] E. Fisher, et al. 2006. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. Health Affairs. Web Exclusive: w44–w57
[40] Department of Veterans Affairs website. http://www.va.gov/VATAP/
[41] Technology Evaluation Center website. http://www.bcbs.com/betterknowledge/tec/what-is-tec.html
[42] C. Schoen, et al. 2007.
[43] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[44] Blue Ribbon Commission for Health Care Reform. 2008.
[45] Puget Sound Health Alliance website. http://www.pugetsoundhealthalliance.org/
[46] Institute for Clinical Systems Improvement website. http://www.icsi.org/
[47] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[48] Washginton Health Care Authority website. http://www.hca.wa.gov/shtap/
[49] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.

[50] Blue Ribbon Commission for Health Care Reform. 2008.
[51] Patient-Centered Primary Care Collaborative. 2007. A New Physician Payment System to Support Higher Quality, Lower Cost Care Through a Patient-Centered Medical Home. Available: http://www.pcpcc.net/content/physician-payment-reform.
[52] A. Gorroll, et al. 2007. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. Journal of General Internal Medicine. 22(3)410–15.
[53] The Legislative Commission on Health Care Access. 2008.
[54] C. Schoen, et al. 2007.
[55] Blue Ribbon Commission for Health Care Reform. 2008.
[56] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.
[57] F. de Brantes and J. A. Camillus. 2007. Evidence-Informed Case Rates: A New Health Care Payment Model. The Commonwealth Fund. Available: http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=478278
[58] Minnesota Department of Health. 2007. Payment Reform: Background Information Prepared for the Health Care Transformation Task Force. Department of Health. Available: http://www.health.state.mn.us/divs/hpsc/hep/transform/091707documents/paymentreformfinal.pdf
[59] C. Schoen, et al. 2007

Geography And The Debate Over Medicare Reform

A reform proposal that addresses some underlying causes of Medicare funding woes: geographic variation and lack of incentive for efficient medical practices.

by John E. Wennberg, Elliott S. Fisher, and Jonathan S. Skinner

ABSTRACT: Medicare spending varies more than twofold among regions, and the variations persist even after differences in health are corrected for. Higher levels of Medicare spending are due largely to increased use of "supply-sensitive" services—physician visits, specialist consultations, and hospitalizations, particularly for those with chronic illnesses or in their last six months of life. Also, higher spending does not result in more effective care, elevated rates of elective surgery, or better health outcomes. To improve the quality and efficiency of care, we propose a new approach to Medicare reform based on the principles of shared decision making and the promotion of centers of medical excellence. We suggest that our proposal be tested in a major demonstration project.

In some regions of the United States Medicare pays more than twice as much per person for health care as it pays in other regions. For example, age-, sex-, and race-adjusted spending for traditional, fee-for-service (FFS) Medicare in the Miami hospital referral region in 1996 was $8,414—nearly two and a half times the $3,341 spent that year in the Minneapolis region.[1]

Even after differences in price levels across regions are adjusted for, there are no obvious patterns that suggest why some areas spend more than others. Spending in urban areas in the Northeast tends to be higher than average, but spending in rural regions in the South and urban areas in Southern California is as high or even

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higher. And the dollar transfers involved are enormous. The difference in lifetime Medicare spending between a typical sixty-five-year-old in Miami and one in Minneapolis is more than $50,000, equivalent to a new Lexus GS 400 with all the trimmings.[2]

Regional differences in spending have a more immediate consequence for the elderly who are enrolled in Medicare health maintenance organizations (HMOs), since capitated Medicare payments to HMOs under the Medicare+Choice (M+C) program are tied directly to local FFS per capita costs.[3] Thus, HMOs in high-cost areas get paid more per subscriber and can therefore provide their clients with drug benefits and prescription eyeglasses, services that HMOs in low-cost regions cannot provide.[4] Efforts by the federal government to raise HMO capitation rates in low-cost areas have generated problems of their own. A recent report to Congress by the Medicare Payment Advisory Commission (MedPAC) ultimately targeted variation in FFS Medicare payments as the culprit:

> If a large portion of the [geographical] difference is due to differences in practice patterns that have no apparent effects on quality of care, then Congress may want to examine whether Medicare payment policy should accommodate that variation...The answer will not lie in changing M+C policy alone. Policies to limit variation in practice patterns will have to be implemented in the FFS sector as well.[5]

In light of the policy recommendations above, we consider four distinct questions. First, can the variations in Medicare spending be explained by differences in illness? In other words, is spending higher in some regions simply because people there are sicker? Second, how do the patterns of practice vary, and what types of health care services do the elderly receive in high-spending regions that they do not get in low-spending regions? Do residents of high-spending regions receive more elective surgery or more effective care? Third, how efficient is this additional spending? Do people in high-spending regions prefer the additional care or experience better health as a result? Finally, how can the Medicare system (and the health care system more generally) be reformed to improve both the quality of care and the efficiency of the health care system?

Do Differences In Illness Levels Explain Higher Medicare Spending?

Health services use is, of course, strongly related to health status. Data from the Medicare Current Beneficiary Survey (MCBS) show that those who reported excellent health spent an average of 1.5 days per year in the hospital, while those in poor health spent an average of 4.2 days in the hospital.[6] There also are differences in health status across regions. We created an "illness index" that uses regional rates of heart attack, stroke, hip fracture, cancer, gastrointestinal hemor-

"Greater Medicare spending does not purchase the infrastructure needed to ensure compliance with evidence-based medicine."

rhage, and death of Medicare beneficiaries to quantify the underlying disease burden in a region. These measures were chosen because the hospitalization records for the illnesses are accurate reflections of their true incidence in the population; nearly every elderly person with a hip fracture ends up in the hospital. (Not surprisingly, the Social Security Administration is assiduous about measuring mortality accurately.) Using regression analysis, we found that the health of enrollees in Grand Junction, Colorado, one of the healthiest regions in the United States, implies that their per capita Medicare spending should be about 20 percent below the national average. By contrast, the regression suggests that those living in Birmingham, Alabama, one of the least healthy regions, should receive about 24 percent above the national average.[7] These estimated differences in underlying health are substantial and could be used, for example, in "risk-adjusted" regional capitation payments for Medicare enrollees. Still, they explain just 27 percent of the (weighted) variation in Medicare spending across regions. Consequently, illness-adjusted Medicare spending differs greatly across regions.[8] Other studies with homogeneous patient populations (such as those with hip fracture or heart attack) confirm that substantial differences in Medicare use and spending across U.S. regions are largely independent of beneficiaries' need for services.[9]

How Do Practice Patterns Differ In High-Spending Regions?

We considered these questions by examining variations in three categories of services: effective care, preference-sensitive care, and supply-sensitive care. The categories of care are distinguished by the relative roles of medical theory and opinion, medical evidence, the per capita supply of medical resources, and the importance and appropriateness of patients' preferences in choosing a treatment option (Exhibit 1).

■ **Effective care.** Effective care comprises services whose use is supported by well-articulated medical theory and strong evidence for efficacy, as determined by clinical trials or valid cohort studies. The category is further restricted to interventions that virtually all patients should want as part of the contract they make with their health care systems. Effective-care indicators, based on Health Plan Employer Data and Information Set (HEDIS) measures and ex-

EXHIBIT 1
Categories Of Medical Services

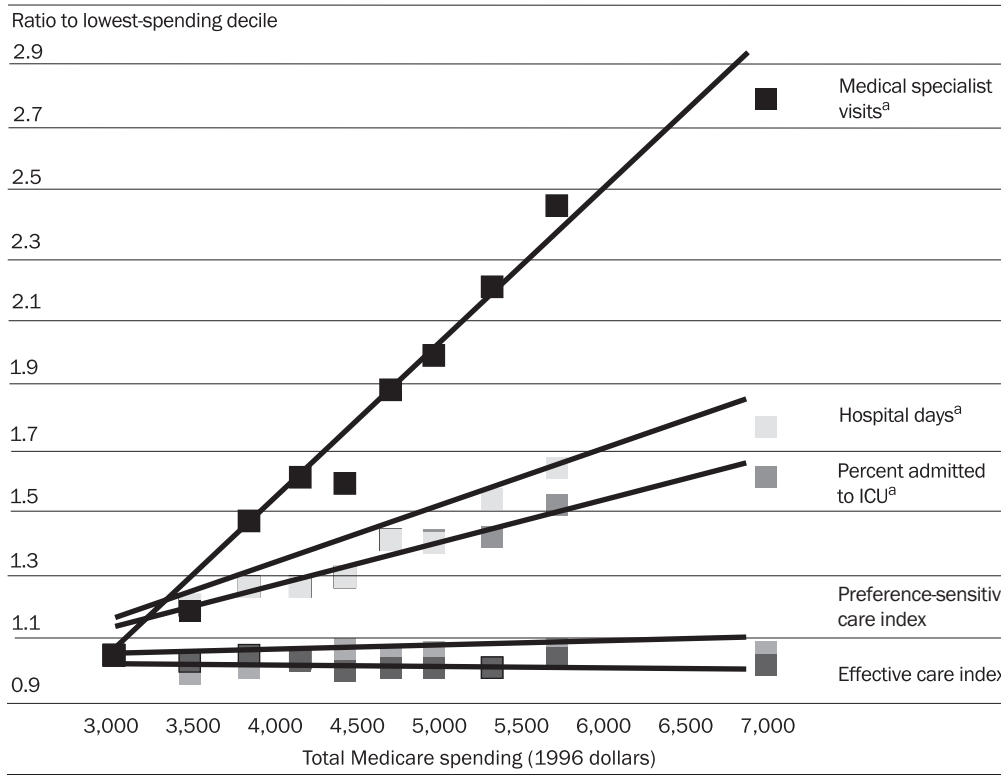
	Factors that influence utilization			
	Medical theory	**Medical evidence**	**Per capita supply of resources**	**Importance of patients' preferences**
Effective care	Strong	Strong	Weak	Weak
Preference-sensitive care	Strong	Variable	Variable	Strong
Supply-sensitive care	Weak	Weak	Strong	Variable

SOURCE: Authors' analysis.
NOTES: *Effective care* refers to services of proven effectiveness that involve no significant trade-offs—all patients with specific medical needs should receive them. Conflict between patients and providers over the value of care is minimal. *Preference-sensitive care* involves trade-offs; decisions should therefore be based on patients' preferences and values. Although opinions are strongly held by clinical advocates, supporting scientific evidence may be weak or strong. The effect of supply on rates of discretionary care is variable. Patients' and providers' values are often in conflict. *Supply-sensitive care* is generally provided in the absence of specific clinical theories of benefit governing the relative frequency of use. Medical texts provide little or no guidance on when to schedule a revisit, perform a diagnostic test, hospitalize, or admit to intensive care. However, utilization rates are strongly influenced by the supply of resources. In some cases, patients' preferences and values should play a central role, particularly for end-of-life care.

panded for the *Dartmouth Atlas of Health Care*, include vaccination for pneumococcal pneumonia; mammography screening for breast cancer and screening for colon cancer; eye examinations for diabetics; HgA1c and blood lipid monitoring for diabetes; and, for heart attack victims, the prescription of aspirin therapy, beta-blockers, angiotensin converting enzyme (ACE) inhibitors and early reperfusion with thrombolytic agents, or percutaneous transluminal coronary angioplasty (PTCA). For each of these services, use rates vary extensively among hospital referral regions. For example, among patients with heart attacks who were considered "ideal candidates" for beta-blockers, those who actually got the needed drug ranged from 5 percent to 92 percent of patients among the 306 *Dartmouth Atlas* Hospital Referral Regions (HRRs). Unfortunately, most regions exhibited substantial underuse: Compliance with evidence-based practice guidelines exceeds 80 percent of patients in only eight regions; in ten regions, compliance was less than 20 percent. The percentage of female Medicare beneficiaries (ages 65–69) who received a mammogram at least once over a two-year period (as recommended by the U.S. Preventive Services Task Force) ranged from 21 percent to 77 percent, with all regions falling below the "best-practice" benchmark provided by Kaiser Permanente South. The most important explanation for such variation in effective care appears to be the lack of infrastructure to ensure compliance with well-accepted (evidence-based) standards of practice.

The important question for our purpose is, Does higher Medicare spending buy better quality? Exhibit 2 suggests that it does not. On average, there is as much underuse in high-cost as in low-cost regions, which suggests that greater spending does not purchase the

EXHIBIT 2
Use Of Effective Care, Preference-Sensitive Care, And Supply-Sensitive Care Among Hospital Referral Regions, Grouped By Per Enrollee Spending Level



SOURCE: *Dartmouth Atlas of Health Care,* 1998 and 1999.
NOTES: Hospital referral regions were ranked according to per enrollee spending adjusted for age, sex, and race and put into ten groups. The exhibit gives the average per enrollee spending in each group. Use rates for each category of utilization were calculated and expressed as a ratio to rates in thirty-one hospital service areas with lowest spending. Medical specialist visits, hospital days, and percent admitted to ICU are all measures of supply-sensitive care. The index for effective care use is the sum for rates for the eleven indicators cited in the text; the index for preference-sensitive care is the sum for rates for the ten surgical procedures profiled in the 1999 *Dartmouth Atlas of Health Care.* ICU is intensive care unit.
[a] Care provided per decedent in the last six months of life.

infrastructure needed to ensure compliance with the standards of practice dictated by evidence-based medicine.

■ **Preference-sensitive care.** Preference-sensitive care is clinical services where for many patients at least two valid alternative treatment strategies are available. Since the risks and benefits of the options differ, the choice of treatment involves trade-offs. In theory, these treatment choices should depend on informed patients' making decisions based on the best clinical evidence. In practice, however, treatment choices appear to be determined largely by local medical opinion concerning the value of surgery or its alternatives. For example, cardiac bypass surgery rates exhibit about a fourfold range of variation, from three per thousand (adjusted for age, sex, and race) in Albuquerque, New Mexico, to more than eleven per

thousand in Redding, California. The rates are strongly correlated with the numbers of per capita cardiac catheterization labs in the regions but not with illness rates as measured by the incidence of heart attacks in the region. Surgery for back pain varies even more, but the rates are not strongly correlated with supply of beds or surgeons.

While there is a large body of research on bypass surgery, there is much less for other surgical procedures. For example, the surgical decision regarding treatment of low back pain must be made in the absence of evidence from clinical trials. It seems likely that individual physicians' opinions, rather than patients' preferences, explain the more than sixfold variation in surgery rates among the 306 hospital referral regions. Indeed, regions do not show consistently high or low rates across surgical procedures, and for most procedures the patterns are not explained by the supply of surgeons. Rather, the patterns are idiosyncratic, with high rates for some discretionary procedures and low rates for others—a phenomenon we refer to as the "surgical signature." The use of discretionary surgery is, on average, not higher in regions with greater spending (Exhibit 2).

■ **Supply-sensitive services.** In contrast to effective care and preference-sensitive care, the medical theory governing decisions about the use of hospitals as a site of care or the frequency of physician visits and diagnostic tests is much less well developed. Medical texts and journals, for example, are silent on the incremental value of three-month versus six-month intervals between physician visits for patients with such conditions as diabetes or hypertension. These sources are similarly uninformative with regard to the indications for hospitalization, use of intensive care, and use of imaging and other diagnostic tests for patients with a host of chronic illnesses. Regions differ greatly in these measures of intensity.

These variations are particularly pronounced during the last six months of life, a period of time when many Medicare enrollees are quite sick and which accounts for more than 20 percent of total Medicare expenditures.[10] During 1995–96 the average numbers of visits to medical specialists ranged from two per decedent in Mason City, Iowa, to more than twenty-five in Miami, Florida.[11] The average number of days per decedent spent in hospital ranged from 4.6 in Ogden, Utah, to 21.4 in Newark, New Jersey.

A similar pattern holds for admissions to intensive care units (ICUs) in the last six months of life, with nearly half of all decedents experiencing an ICU admission in Miami, Florida, compared with only 14 percent in Sun City, Arizona. These variations cannot reasonably be attributed to differences in illness: During the last six months of life most people are ill, regardless of where they live.

Moreover, similarly situated communities often have strikingly different rates. For example, while in Sun City, Arizona, only 14 percent of decedents experience an ICU admission in the last six months of life, 49 percent and 45 percent of decedents in Sun City, California, and Sun City, Florida, respectively, do so. The local supply of medical specialists and acute care hospital capacity explains 41 percent of the variation in end-of-life care intensity across HRRs.[12] We therefore adopt the term "supply-sensitive" to capture these indicators of health care intensity for chronically ill patients.[13]

The incremental Medicare dollar spent in regions with higher-than-average spending tends to be for medical specialist visits, diagnostic tests, and use of intensive care and hospitalizations for medical conditions.[14] Exhibit 2 shows the close correlation between per capita Medicare spending for the entire Medicare population and the average number of specialist visits for those in their last six months of life. Thus we view the incremental Medicare dollar as flowing not simply toward more specialist visits in the general elderly population but, more specifically, toward specialist visits concentrated among the population with chronic and ultimately life-threatening diseases. Many of these patients do not survive and are thus well represented in our sample of people in their last six months of life.[15]

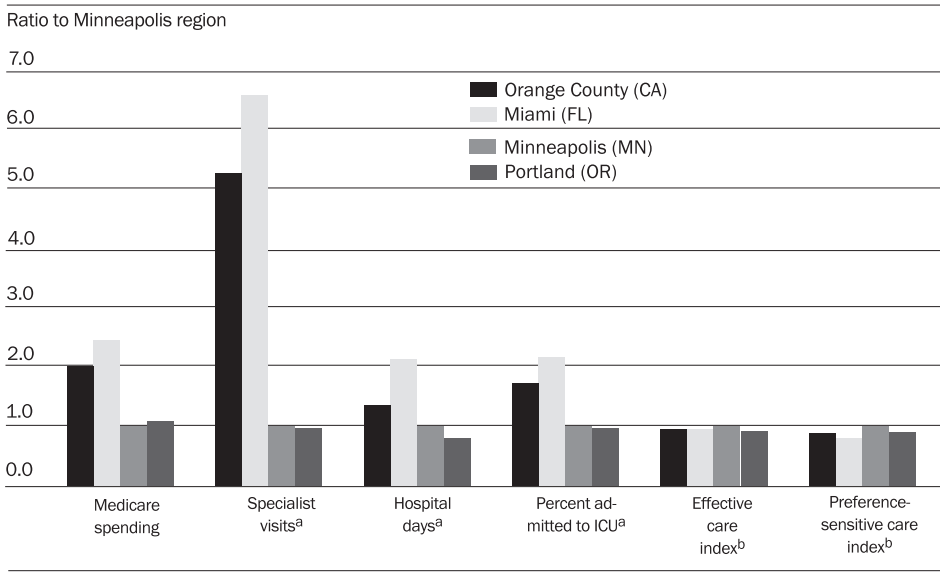
The strong associations between higher spending and greater use of supply-sensitive care, and the lack of association between more spending and more preference-sensitive or effective care, can be seen in the medical care of residents of four regions that represent either very high or very low levels of overall spending: Miami, Florida; Orange County, California; Portland, Oregon; and Minneapolis, Minnesota (Exhibit 3). Age-, sex-, and race-adjusted spending in Miami, for example, is 2.45 times greater than in Minneapolis. During the last six months of life the "extra" spending purchases 6.55 times more visits to medical specialists, 2.13 times more hospital days, and 2.16 times more admissions to an ICU. By contrast, rates for effective care and preference-sensitive care are slightly lower in Miami than in Minneapolis.

Is More Better?

We considered this question for each of the three categories of service. It seems clear that for our eleven indicators of effective care, more is better. One study suggested that regions with better quality are associated with better survival rates in the Medicare population.[16] On these measures of quality, all regions in the United States are practicing subpar medicine—use rates are too low.

In the case of preference-sensitive care, the significance of the

EXHIBIT 3
Comparison Of Medicare Spending, Supply-Sensitive Care, Preference-Sensitive Care, And Effective Care For Orange County, Miami, Minneapolis, And Portland Hospital Referral Regions, 1995–1996



SOURCE: *Dartmouth Atlas of Health Care,* 1995–96 database.
NOTE: Rates are given as ratio to Minneapolis hospital referral region (valued as 1.0).
[a] Care provided per decedent in the last six months of life.
[b] See Exhibit 2 for definitions.

variation in use rates cannot be strictly interpreted from the point of view of the patients' welfare, since it is not clear whether patients actually had much of a say in determining which treatment they received. Clinical studies of shared decision-making programs designed to inform patients about the treatment options available for low-back pain, prostatic hyperplasia, and stable angina do, however, suggest that the amount of surgery now provided in many regions exceeds what an informed Medicare population would demand.[17]

Does greater overall health care intensity from the provision of "supply-sensitive" medical care result in better health outcomes? To address this question, we have evaluated the natural experiments afforded by the variations in care intensity among regions. Studies at the population level indicate no net advantage in terms of life expectancy for Medicare enrollees living in regions with more hospital resources (and hospitalizations) and greater care intensity as measured by more aggressive treatment patterns during the last six months of life.[18] Longitudinal (cohort) studies of patients with similar diseases (such as hip fracture) who have been followed for a number of years also show that patients living in high-care-intensity regions gain no survival advantage over those in low-intensity regions.[19]

The major limitation of these studies is the possibility that beneficiaries in high-spending regions could achieve gains in their quality of life. Several lines of research provide at least suggestive evidence that quality of life in high-intensity regions may not be better than in low-intensity regions. First, case-mix-adjusted longitudinal studies of Medicare beneficiaries found that those residing in high-intensity regions achieved no gain in relief from angina or improvement in function.[20] Second, two randomized trials testing the impact of greater medical care intensity for patients with chronic disease found no benefit in terms of functional status and quality of life.[21] Third, evidence from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) study suggests a poor match between patients' preferences and how patients with severe chronic illness are actually treated. Patients who stated that they would prefer an out-of-hospital death were no less likely to die in a hospital than were patients who expressed a preference for an in-hospital death. What did matter was local hospital capacity: The overall supply of hospital resources in the region effectively predicted whether the patient died in a hospital.[22] Because most elderly people express a preference for a less intensive approach to care as death approaches, greater intensity could lead to poorer quality of care among this group.

Budgetary Effects Of Reducing Regional Disparities

How much money is at stake? We have used benchmarks for Medicare spending from low-cost regions to estimate how much money would be "saved" if regions with higher spending were brought down to the level of the benchmark. Our estimates are based on 1996 spending. In that year, spending under traditional Medicare was about $138.3 billion, and per capita spending reached $4,990. If, on an age-, sex-, and race-adjusted basis, spending levels in the lowest decile were realized in all higher regions, total spending would have been just $98.2 billion, or a savings of $40 billion (28.9 percent).[23] In theory, these savings could be used to fund a prescription drug benefit without any increase in taxes or in elderly persons' premiums. Any balanced-budget reform would entail winners and losers, but we argue that every region ultimately would gain if such reallocation were to occur, because the elderly would receive prescription drug benefits of great value to them and would lose medical services of little, or possibly negative, value.[24]

In theory, the government could effect the entire $40 billion in savings simply by imposing regional budgetary caps benchmarked (on the basis of age, sex, and illness) to the low-cost areas. Under

this approach, local regions would receive a fixed budget for Medicare services. If the quantity of services provided is above the benchmarked levels, the only way to meet the budgetary cap is to slash how much Medicare pays per procedure or physician visit. Such a reform would generate adverse political repercussions, as well as perverse incentive effects. Some physicians would work harder to maintain their prior level of income, while others might stop seeing Medicare patients because of the lower reimbursement rates. Physicians practicing conservative medicine in high-intensity areas would be punished the most. Most important, these incentives would do nothing to address the fundamental questions about the value of Medicare services raised by the variation phenomena.

Improving The Quality And Efficiency Of Medicare

We suggest that the first task for Medicare reform is to improve the quality of care. We have identified three categories of unwarranted variation affecting the quality and efficiency of care supported by the Medicare program. To address these shortcomings, we propose the following goals for Medicare reform: (1) eliminate underprovision of effective care; (2) establish patient safety; (3) reduce scientific uncertainty through outcomes research; (4) establish shared decision making for preference-based treatments, chronic disease management, and end-of-life care; (5) establish accountability for capacity; and (6) promote conservative practice when greater care is wasteful if not harmful. The strategies described below have been demonstrated in selected specific settings to achieve these goals.

■ **Strategies to ensure that effective care is provided and medical errors are minimized.** The organizational structure of medical care is critical in ensuring that effective care is not underused. Integrated health systems such as staff- and group-model HMOs can deliver effective care to almost all of their enrollees, although they are losing market share to less tightly structured health plans. (By contrast, HMOs that contract with individual physician groups [the "network" model] have been less successful in implementing these quality standards.) A few exemplary organizations, working voluntarily, have developed the administrative and research infrastructure to implement "best practices" and have consequently reduced mortality and morbidity resulting from medical errors. Notable projects include the Northern New England Cardiovascular Study Group and Intermountain Health Systems.[25] Yet these examples are not common, and there is no mechanism in the Medicare program designed to reward providers that adopt these best-practice strategies.

■ **Strategies to improve the quality of patient-physician deci-**

"Shared decision making has not been widely implemented, perhaps because of fears about loss of autonomy and income."

sions regarding treatment for which patients' preferences should play a role. Research on health outcomes is important to remedy significant gaps in scientific knowledge. Throughout the 1990s the Agency for Healthcare Research and Quality (AHRQ) undertook programs that encouraged leading health care organizations to develop research programs, and, more recently, the National Institutes of Health (NIH) has supported networks of clinical trials to evaluate the outcomes of treatment options involving preference-sensitive surgery.[26] The Maine Medical Assessment Foundation has demonstrated that providers will respond to practice variations by participating in outcomes research.[27] Many surgical procedures involve important trade-offs that should depend on patients' preferences.[28] Shared decision making, in which decision support systems are used to provide patients with balanced information about treatment options for their specific disease, is designed to provide a better match between patients' preferences and the treatment they receive. It also has led to changes in the demand for intensive treatments. In most studies of shared decision making, overall surgery rates have declined. Shared decision making has not been widely implemented, perhaps because of providers' fears about loss of autonomy and income.

■ **Strategies to promote accountability for capacity and conservative practice where more care is wasteful, if not harmful.** Attempts to limit hospital capacity through public-sector health planning have met with only limited success. The classic HMO (in contrast to the network HMO model) is generally the only entity that practices private-sector health planning based on population benchmarks in reaching decisions on how many hospital beds to build (or contract for) and how many physicians and other health care workers to hire. Promoting more conservative practice styles, particularly for end-of-life care, is the goal of an increasing number of physicians, notably primary care physicians, hospitalists, geriatricians, and palliative care physicians. However, to affect overall Medicare efficiency, efforts to promote conservative practice styles also must lead to a reduction in excess capacity.

While these approaches have led to improvements in quality of care, they are often piecemeal reforms. Also, the Medicare program is not structured to ensure that these efforts receive the support they deserve; indeed, conservative strategies toward health care are

typically rewarded with lower Medicare reimbursements. We next propose an approach that encourages and rewards health care organizations that improve the quality and efficiency of health care.

Establishing Comprehensive Centers For Medical Excellence

We propose a new structure for Medicare reforms that focuses simultaneously on increasing the use of effective care and reducing medical errors, improving the quality of medical decision making, and reducing supply-sensitive care. We believe that this structure can help to meet Medicare's goals for medical excellence as set forth above. In traditional FFS Medicare, bills are paid whether or not the service was appropriate and whether the hospital or provider is of high or low quality. Only in the case of outright fraud might Medicare shrink from paying. The idea behind our proposed Comprehensive Centers for Medical Excellence (CCMEs) is to allow Medicare to reward both quality and efficiency.

To qualify, hospitals, provider networks, or organizations representing regional coalitions would agree to establish "best-practice" models such as those discussed above to address the underlying causes of variation. CCMEs would in turn partner with the Medicare program, AHRQ, and the NIH to develop a systematic, long-term approach to building the organizational and scientific infrastructure required to bring about fundamental improvements in the performance of the U.S. health care industry. The feasibility of the CCME program thus depends on the willingness of the leading U.S. health care organizations and the federal government to establish a partnership. As the essential first step, we suggest that the federal government undertake a major demonstration project to test the hypothesis that the partnership can fruitfully address each category of unwarranted variations.

■ **Promote effective care and patient safety.** As noted above, staff- and group-model HMOs (the so-called classic HMOs) provide the best model for implementing organizational structures that ensure effective care. Like classic HMOs, CCMEs would be expected to develop procedures and processes of care that, when used with "real-time" Medicare claims or internal data, could develop strategies for assuring the provision of safe and effective care.

The remedy for unexplained variations in surgical mortality rates and other problems of patient safety depends on the active participation of health care providers in programs to improve their practices. Under the CCME project, participating organizations would be expected to develop collaborative strategies to discover the cause of medical errors and create solutions that improve patient safety,

following the best-practice models discussed above. The federal government, through Medicare and AHRQ, would provide financial support and scientific peer review to build and sustain the necessary infrastructure regarding quality standards. The CCME structure also could be used to facilitate additional proposals developed in the recent Institute of Medicine (IOM) study on improving health care quality.[29]

■ **Reduce unwarranted variation in preference-sensitive care.** First, CCME organizations would be asked to provide shared decision-making tools (such as videos) to patients with diseases such as breast cancer, prostate cancer, angina, and lower back pain. Second, they would be encouraged to participate in clinical research designed to improve the quality of medical knowledge about the outcomes of specific treatments for a wide spectrum of patient characteristics. This research could include outcomes research programs, including clinical trials, sponsored by AHRQ and the NIH.

■ **Reduce overuse of supply-sensitive care.** CCMEs would be asked to develop clinical programs to reduce unwarranted variations in end-of-life care and other examples of overuse of supply-sensitive service, fostering the approach championed by geriatricians and palliative care physicians. Attention also should be paid to the developing role of hospitalists in the reduction of overuse of hospitalizations and ICU stays.[30]

Like classic HMOs, CCMEs would strive to become accountable for their capacity by adopting population-based approaches to resource allocation in the planning of facilities and the hiring of the workforce. They would seek to base their resource decisions about the size of each sector of care on benchmarks provided by efficient health care organizations. Medicare would provide real-time claims data to compare local capacity with national benchmarks.

Our strategy for achieving accountability for capacity and fostering conservative practice styles is based on research showing that the practice styles of individual health care organizations can be profiled with regard to their use of supply-sensitive care. Under FFS Medicare a given organization typically serves a "defined population," a loyal group of patients who receive most of their care from that institution. Loyalty is particularly strong for patients with chronic illness. Thus, adjusted for age, sex, race, illness, and price, relative performance can be measured and (relatively) efficient health care organizations identified. Even within traditionally high-cost regions, overall costs vary widely among hospitals.[31]

A critical role of a demonstration project will be to refine approaches to reducing unwarranted levels of supply-sensitive services without leading to the public perception that this means a

reduction in the quality of care. We hope that increased awareness of how capacity and greater intensity affects the quality of life for those with chronic and life-threatening disease (for example, increased use of mechanical ventilators, painful diagnostic testing, and the risk of dying in an ICU) will help to create popular consensus for limiting the intensity of supply-sensitive care in high-cost regions for reasons of quality, not just cost containment.

■ **Refine monitoring systems.** Another important objective of the demonstration project would be to refine the monitoring systems used to evaluate performance in meeting the goals for medical excellence. While routine claims data serve well as the basis for patient registries required to evaluate performance, the advantages and limitations of these databases need to be better understood. Moreover, claims data need to be augmented by critical information extracted from patient records and obtained directly from patients. AHRQ and the participating health care organizations should work together to assure that validated performance measures are available to objectively measure progress in reducing unwarranted variations. These measures are essential for the selective-contracting process.

■ **Reward more efficient resource use.** An important objective of the demonstration project would be to develop appropriate approaches (including financial incentives) that reward more efficient resource levels without unreasonable disruptions of infrastructure and professional careers. The present Medicare FFS reimbursement system does not reward physicians and health care organizations that devote professional time to improving patient safety or reducing underuse of effective care. Physicians (and their institutions) who encourage shared decision making face negative economic consequences when their patients prefer less care. Institutions that reduce supply-sensitive care are unable to retain the savings to invest in productive uses, even when their overall per capita spending rate is low. Federal participation and willingness to support experiments in the fee schedule to remedy these disincentives are critical to the success of the project.

■ **Promote implementation.** If successful, the demonstration project would provide real-world performance standards or best-practice models for achieving medical excellence.[32] The next step would be to promote their wide implementation, which may require cooperative as well as competitive strategies. In regions where population density can support more than one integrated health care system, a market strategy could be used to encourage FFS patients to seek care from the higher-quality provider. Medicare could establish a "preferred provider" through selective contracting. By choosing this option, Medicare enrollees would benefit through

a reduction in premiums and copayments for services provided at the CCME. Under a premium support program like that in the Breaux-Thomas proposal, Medicare could subsidize the price of insurance policies (or FFS care) centered at CCMEs.[33]

In many nonurban areas the population is not large enough to support more than one integrated health care system.[34] In such regions, cooperative rather than competitive strategies are required to build the infrastructure to assure that all segments of the population have access to high-quality care. Cooperative strategies also may prove effective in urban regions; one example is the Pittsburgh Regional Health Care Initiative, a coalition of regional hospitals, clinicians, health plans, and major corporate purchasers.

We are fully aware that major political barriers will exist in the implementation phase. We believe, however, that lessons learned from the demonstration projects can reduce those barriers, and we therefore urge that the organizations selected for participation be located in both rural and urban settings. We also encourage the use of strategies that encompass both cooperative and competitive approaches. Perhaps the most difficult barrier to overcome is the lack of trust and the cynicism that pervades relations between doctors, patients, health plans, and government. A demonstration project that brings the prestige of the NIH and AHRQ and leading U.S. health care organizations into a partnership for quality may help to overcome these barriers.

Implementation Steps

There are serious defects in the quality of care now provided in FFS Medicare. The gains from improving the quality of care are too large to be ignored.[35] They include preventing and reducing morbidity and saving lives and money. The gains from reducing disparities in Medicare spending are also too large to be ignored. The goals are not unreasonable; after all, large metropolitan areas such as Minneapolis and Portland are getting along just fine with relatively modest Medicare expenditures.

We propose addressing the quality issues and the savings issues simultaneously through a new approach that relies on CCMEs, provider groups, hospitals, and regional consortia that provide high quality and efficient care. We suggest a two-step implementation process.

The initial step, which has been the primary focus of this paper, is a demonstration project to test the hypothesis that leading health care organizations will partner with the federal government to reduce unwarranted variations and meet six goals for medical excellence. The demonstration is designed to help us understand what

works and what does not work. At the local level, "test-case" innovations in the traditional Medicare benefit package to improve quality, adopt shared decision making, and create incentives to redirect health providers toward more caring and less intensity would yield best-practice models on which to base a national program. The project would include health care organizations serving urban and rural regions and would be designed to gain information on the feasibility of cooperative as well as competitive strategies for achieving high quality and efficiency.

The second step would be to assure that all Medicare enrollees have access to high-quality care and to reduce the variation in Medicare spending among regions, to move the country toward the benchmarks provided by low-cost regions such as Portland and Minneapolis. While incrementalism is more likely in the near future, at some point in the not-so-distant future major Medicare reform will be inevitable. We believe that this inevitability should add urgency to our suggestion of a major demonstration project. The more we know about what works and what does not, the brighter will be the future of health care in the United States.

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NOTES

1. J.E. Wennberg and M.M. Cooper, eds., *The Quality of Medical Care in the United States: A Report on the Medicare Program, The Dartmouth Atlas of Health Care 1999* (Chicago: American Health Association Press, 1999).
2. This lifetime calculation assumes that the relative differences in Medicare spending persist, life expectancy conditional on reaching age sixty-five is fifteen years, the discount rate is 3 percent, and the annual rate of growth in real per capita Medicare spending is 2 percent. See D. Feenberg and J. Skinner, "Medicare Transfers across States: Winners and Losers," *National Tax Journal* (September 2000): 713–732.
3. The HMO payment schedule (the adjusted average per capita cost, or AAPCC) is based on a blend of national risk-adjusted rates (10 percent) and local FFS expenditures (90 percent).
4. See T.D. McBride, "Disparities in Access to Medicare Managed Care Plans and Their Benefits," *Health Affairs* (Nov/Dec 1998): 170–180; and E. Martin, "Tough Times as Medicare HMOs Fold," *ACP-ASIM News* (February 1999), <www.acponline.org/journals/news/feb99/tough.htm>.
5. Medicare Payment Advisory Commission, *Report to Congress: Medicare Payment Policy* (Washington: MedPAC, March 2001), 115.
6. J.E. Wennberg and M.M. Cooper, eds., *The Dartmouth Atlas of Health Care 1998* (Chicago: American Health Association Press, 1998).
7. These estimates are based on a least-squares regression where age-sex-race-price–adjusted Medicare spending is the dependent variable and the inde-

pendent variables are age-sex-race–adjusted incidence of the "low variation" illnesses (and mortality) discussed in the text. See also J. Skinner and E. Fisher, "Regional Disparities in Medicare Expenditures: Opportunity for Reform," *National Tax Journal* (September 1997): 413–425. A full set of illness adjustment measures by region is available at <www.dartmouthatlas.org>.

8. A recent study explained up to 70 percent of the variation in regional Medicare spending by including a variety of additional health and demographic variables. D. Cutler and L. Sheiner, "The Geography of Medicare," *American Economic Review* (May 1999): 228–233. The additional health variables alone did not improve the predictive power of the regression by a significant degree. And while the demographic variables such as the percentage of deaths occurring at older ages and the percentage of the population that is Hispanic were suggestive, they also could be reflecting other variables at the population level. M. Susser, "The Logic in Ecological: I. The Logic of Analysis," *American Journal of Public Health* (May 1994): 825–829. For example, the authors find that HRR-level Medicare expenditures are positively associated with the Hispanic share of the population. However, at the micro level, per capita Medicare expenditures for Hispanics are slightly lower than those for non-Hispanics. Centers for Medicare and Medicaid Services, *Health and Health Care of the Elderly Population: Data from the 1996 Medicare Current Beneficiary Survey* (2000), Table 4.8. We suspect that expenditures for both non-Hispanic and Hispanic enrollees are higher in Florida and Texas, states with a larger number of Hispanic residents. Similarly, a larger fraction of elderly persons dying at older ages predicts lower Medicare expenditures, even among those who do not die in that year. This finding is consistent with the development of a more conservative strategy for all their patients by physicians in regions with a larger fraction of deaths among the oldest Medicare enrollees (age eighty-five and older). For more detail on this finding, contact John Wennberg, <john.wennberg@dartmouth.edu>.
9. See C.A. Gatsonis et al., "Variations in the Utilization of Coronary Angiography for Elderly Patients with an Acute Myocardial Infarction: An Analysis Using Hierarchical Logistic Regression," *Medical Care* 33, no. 6 (1995): 625–642; E.S. Fisher et al., "Hospital Readmission Rates for Cohorts of Medicare Beneficiaries in Boston and New Haven," *New England Journal of Medicine* 331, no. 15 (1994): 989–995; and D. Chau, E.S. Fisher, and J. Skinner, "The Importance of Regional Practice Style in a Cohort of Elderly Hip Fracture Patients" (Unpublished manuscript, Dartmouth Medical School, 2001).
10. J.D. Lubitz and G.F. Riley, "Trends in Medicare Payments in the Last Year of Life," *New England Journal of Medicine* 328, no. 15 (1993): 1092–1096.
11. For more on dramatic variations in physician revisit intervals, see J.K. Tobacman et al., "Variation in Physician Opinion about Scheduling of Return Visits for Common Ambulatory Care Conditions," *Journal of General Internal Medicine* 7, no. 3 (1992): 312–316; L.M. Schwartz et al., "Setting the Revisit Interval in Primary Care," *Journal of General Internal Medicine* 14, no. 4 (1999): 230–235; and H.G. Welch et al., "The Role of Patients and Providers in the Timing of Follow-up Visits," *Journal of General Internal Medicine* 14, no. 4 (1999): 223–229.
12. This comes from a regression that explains end-of-life care per decedent, at the HRR level, with hospital bed supply, primary care physicians, and specialists, all on a per capita basis. The regression is weighted by the population age sixty-five and older in each HRR. One could question whether the capacity is itself sensitive to greater demand for specific services. However, we find that much of the variation in hospital capacity is the consequence of migration and not health needs; people move away, but the hospital beds stay, or people

migrate to an area, but relatively few hospital beds are built.

13. The delineation between supply-sensitive and preference-sensitive treatment is more a matter of degree than an absolute difference. While patients' preferences will not likely affect clinical decisions regarding the stabilization of a hip fracture, they may play a role in end-of-life care for the chronically ill.
14. J.S. Skinner, E.S. Fisher, and J.E. Wennberg, "The Efficiency of Medicare," NBER Working Paper no. 8395 (Cambridge, Mass.: National Bureau of Economic Research, July 2001), available at <www.dartmouthatlas.org>.
15. The higher levels of specialist visits are not simply the same specialists visiting much more often; the fraction of patients in their last six months visited by more than ten separate specialists is highly correlated with overall specialist visits. See Wennberg and Cooper, eds., *The Dartmouth Atlas of Health Care 1999*, 192.
16. Skinner et al., "The Efficiency of Medicare."
17. For example, see M.J. Barry et al., "Patient Reactions to a Program Designed to Facilitate Patient Participation in Treatment Decisions for Benign Prostatic Hyperplasia," *Medical Care* 33, no. 8 (1995): 771–782; and M.W. Morgan et al., "A Randomized Trial of the Ischemic Heart Disease Shared Decision Making Program: An Evaluation of a Decision Aid," *Journal of General Internal Medicine* (April 1997) (supp.): 62.
18. See E.S. Fisher et al., "Associations among Hospital Capacity, Utilization, and Mortality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors," *Health Services Research* 34, no. 6 (2000): 1351–1362; H. Krakauer et al., "Physician Impact on Hospital Admission and on Mortality Rates in the Medicare Population," *Health Services Research* 31, no. 2 (1996): 191–211; and Skinner et al., "The Efficiency of Medicare."
19. See Chau et al., "The Importance of Regional Practice Style"; and D.P. Kessler and M.B. McClellan, "Is Hospital Competition Socially Wasteful?" *Quarterly Journal of Economics* 115, no. 2 (2000): 577–616.
20. E. Guadagnoli et al., "Variation in the Use of Cardiac Procedures after Acute Myocardial Infarction," *New England Journal of Medicine* 333, no. 9 (1995): 573–578.
21. See J. Wasson et al., "Telephone Care as a Substitute for Routine Clinic Follow-up," *Journal of the American Medical Association* 267, no. 13 (1992): 1788–1793; and M. Weinberger, E.Z. Oddone, and W.G. Henderson, "Does Increased Access to Primary Care Reduce Hospital Readmissions?" *New England Journal of Medicine* 334, no. 22 (1996): 1441–1447.
22. See the SUPPORT Principal Investigators, "A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)," *Journal of the American Medical Association* 274, no. 20 (1995): 1591–1598; and R.S. Pritchard et al., "Influence of Patient Preferences and Local Health System Characteristics on the Place of Death, SUPPORT Investigators, The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment," *Journal of the American Geriatrics Society* 46, no. 10 (1998): 1242–1250.
23. This figure includes adjustments for the higher reimbursement rates prevailing in high-cost regions such as New York City and San Francisco. See Wennberg and Cooper, eds., *The Dartmouth Atlas, 1999.*
24. Detailed information describing the impact of such a reform on each region is available at <www.dartmouthatlas.org>.
25. G.T. O'Connor et al., "A Regional Intervention to Improve the Hospital Mortality Associated with Coronary Artery Bypass Graft Surgery," *Journal of the American Medical Association* 75, no. 11 (1996): 841–846.
26. For example, the NIH has provided support for clinical trials of back surgery

based at eleven medical centers across the country.

27. R.B. Keller et al., *Searching for Quality in Medical Care: The Maine Medical Assessment Foundation Model,* Pub. no. 00-N002 (Rockville, Md.: Agency for Healthcare Research and Quality, 2000).
28. For example, research on benign prostatic hyperplasia (BPH) demonstrated that while surgery was superior to other treatments in reducing symptoms, its use involved significant trade-offs that depended on patients' preferences: Surgery altered sexual function in a way that some men found very objectionable. The research led to shared decision making, a strategy for clinical decision making that invites the active participation of patients to assure that the patient's own point of view determines the choice of treatment. See J.E. Wennberg et al., "An Assessment of Prostatectomy for Benign Urinary Tract Obstruction: Geographic Variations and the Evaluation of Medical Care Outcomes," *Journal of the American Medical Association* 259, no. 20 (1988): 3027–3030; and Barry et al., "Patient Reactions to a Program."
29. M.P. Hurtado, E.K. Swift, and J.M. Corrigan, eds., *Envisioning the National Health Care Quality Report* (Washington: National Academy Press, 2001).
30. D. Meltzer et al., "Effects of Physician Experience on Costs and Outcomes on an Academic General Medicine Service: Results of a Trial of Hospitalists" (Unpublished manuscript, University of Chicago, January 2001).
31. For example, over several years of follow-up, the per capita use of acute hospital care by cohorts of patients with hip fractures, cancer of the colon, coronary artery disease, and other chronic illness was shown to vary almost twofold among Boston and New Haven teaching hospitals. See Fisher et al., "Hospital Readmission Rates."

32. In preparation for the implementation phase, an important task is to determine who sets the quality standards. The six goals for medical excellence provide a direction, and CCMEs' best-practice strategies will provide benchmarks on which to base criteria for selective contracting. However, finding a consensus view on quality standards and on the measures for monitoring performance will clearly require the participation of national scientific organizations such as the IOM. We suggest that such an agency be given a role in the demonstration project and be asked to make recommendations on how and by whom the quality standards and performance measures could be set and monitored during the implementation phase.
33. The Breaux-Thomas plan proposed to replace the existing Medicare program with one modeled on the Federal Employees Health Benefits Program; enrollees would receive a fixed-dollar contribution (or "premium support") that could then be used to purchase coverage from a set of approved health insurance options. See <medicare.commission.gov/medicare/index.html>.
34. R. Kronick et al., "The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition," *New England Journal of Medicine* 328, no. 2 (1993): 148–152.
35. See Hurtado et al., eds., *Envisioning the National Health Care Quality Report.*

Public Health Perspective
Paying for Prevention

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Prevention efforts in the United States are usually measured in terms of dollars spent and lives lost. Currently, we're not spending a lot of dollars on prevention and we're losing a lot of lives. The 3 leading causes of preventable death — tobacco use, poor diet, and limited exercise — account for about 800,000 deaths annually and for nearly 17% of total healthcare expenditures.[1-3] In a healthcare system that spent about $1.9 trillion[4] in 2004, this represents a huge sum of money.

The real cost, of course, is premature loss of human lives: Tobacco use, diet, and physical activity alone account for more than one third of annual mortality. Including all actual causes of death, about half of annual mortality is preventable. Efforts to control the underlying causes of preventable death, however, are severely underfunded, representing less than 5% of total health spending.[5]

The large burden of preventable deaths is a big target for public health programs. Efforts to improve lives and reduce medical care costs are taking aim, but no direct hit has been registered. Tobacco-related mortality has not yet declined in step with the remarkable progress in tobacco control, and there has actually been a sharp increase in the number of deaths due to poor diet and exercise.[1,6]

Part of the reason that we have failed to finance prevention efforts comes down to basic economic principles. While the cost of preventable diseases is enormous, there is no immediate return on investments in prevention. Any savings would most likely occur in the relatively distant future, beyond normal budget cycles and political campaigns, and returns from any upfront prevention investments by third-party insurance payers would most likely be reaped by another payer many years from now. Our current system

of employer-based third-party insurance has strengths and weaknesses on its own merit, but it is clearly not a good fit for prevention efforts. Barring a radical shift in provider reimbursement, our current approach of squeezing nonmedical costs into the medical reimbursement system is not a sustainable option.

As it stands, there is a stark imbalance between short- and long-term investments in health. Despite the fact that about 50% of the annual burden of deaths is preventable, only 3% to 5% of all medical spending in the United States is directed towards prevention, well care, and population health.[5] An overwhelming proportion — 95% — is directed towards treatment and curative medicine. Historically, this sector of healthcare has had limited impact on overall population health when compared with lifestyle, genetic factors, and environmental exposures.

More recently it seems that the importance of medical care is increasing; it accounts for a bit more than 40% of the gains in life expectancy since 1950, compared with its contribution of less than 20% of the gains in life expectancy over the entire course of the 20th century.[7] Even with this shift, however, dedicating 95% of resources towards medical care can't be supported as a reasonable way to assure a healthy population.
A simple solution would be to change the ratio of expenditures on medical care compared with population-wide health. Even a small shift could make a big difference, and prevention efforts could be considered an investment in Medicare. As the final insurance most Americans will have, Medicare functions as a backstop that catches all the poor health outcomes that result from years of missed prevention opportunities. But there is no mechanism in place for leveraging incentives among the employer-based insurance programs that provide years of care before individuals enroll in Medicare, and in our current political climate of incremental change it is unlikely that Medicare will become a driving force for prevention.

Initial changes in prevention spending patterns may require new financing mechanisms, such as an idea from McGinnis and colleagues[7] to use "small portions of medical care premiums or payments for redeployment for communitywide initiatives."

Developing new resources is often a very difficult task, and in this case it is the critical barrier. In the past, the evidence basis for prevention has been cited as an additional barrier, but at this point we already have the evidence we need to guide our prevention efforts. The Institute of Medicine published a report in 2000 that details the case for intervention strategies using multiple levels of influence based on generic social and behavioral determinants of disease.[8]

Recently published, The Guide to Community Preventive Services includes specific recommendations to improve population health on the basis of scientific evidence.[9] The latest addition to the evidence ranks is a new Cochrane Collaboration focus on behavioral medicine.[10] Although prevention research — like medical care research — must address many unanswered questions, we have enough information to start saving lives with prevention interventions today.

Massive diffusion of responsibility is part of the reason that financing for prevention efforts has not yet been developed. This also creates a challenge for implementation of prevention programs. There are few agencies, organizations, or individual health workers who are in a position to be accountable for future health outcomes that depend on a blend of social and medical programs. After all, behavioral choices are the greatest lever we have to shift the health status of populations, but the evidence has shown that attempting change on an individual basis is a losing proposition.[7] Meaningful prevention efforts require interventions that span medical and nonmedical determinants of health at a community-wide level. The essence of effective prevention is an ecological approach that incorporates aspects of biology, behavior, and the social environment.

For example, consider social support interventions for physical activity in community settings. There is strong evidence of effectiveness for these programs, which can include groups or partner systems to encourage and track physical activity.[9] Individual clinicians, however, have not historically played such a role and may not have available resources. Organizations that affect the social environment (such as schools and religious organizations) may not have a health agenda or the central

organization needed to deliver a consistent program to the general population. What organization or agency should be charged with accountability for prevention and funded to deliver social support interventions for improved health?

Perhaps the best answer is a combination of several agencies including medicine, public health, and social services. A more feasible approach, however, would be to deliver interventions through our existing public health departments at the local and state levels. In fact, the 10 essential public health services include "inform, educate and empower"; "mobilize community partnerships"; and "develop policies and plans to support community health efforts."[11] These services are well aligned with current prevention needs, but public health agencies are not adequately funded to deliver appropriate programs.

We know that our health spending priorities are out of balance, and we have the research evidence needed to start implementing important prevention efforts. Population-based prevention programs deserve financing, and public health departments are in the best position to develop effective interventions. Right now, prevention efforts aren't costing us in terms of dollars, but we're paying in terms of lives; let's aim to reverse that ratio.

References

Mokdad AH, Marks JS, Stroup DF, Gerberding JL. Actual causes of death in the United States, 2000. JAMA. 2004;291:1238-1245. Abstract
Centers for Disease Control. Overweight and obesity: economic consequences. Available at: http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm. Accessed September 11, 2006.
Centers for Disease Control. Annual smoking-attributable mortality, years of potential life lost, and productivity losses — United States, 1997-2001. MMWR Morb Mortal Wkly Rep. 2005;54:625-628. Abstract
Smith C, Cowan C, Heffler S, Catlin A. National health spending in 2004: recent slowdown led by prescription drug spending. Health Affairs. 2006;25:186-196. Abstract
Centers for Disease Control. Effectiveness in disease and injury prevention / estimated national spending on prevention — United States, 1988. MMWR Morb Mortal Wkly Rep. 1992;41:529-531. Abstract
McGinnis JM, Foege WH. Actual causes of death in the United States. JAMA. 1993;270:2207-2212. Abstract
McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Affairs. 2002;21:78-93.

Institute of Medicine. Promoting Health: Intervention Strategies from Social and Behavioral Research. Washington, DC: National Academies Press; 2000. Available at: http://darwin.nap.edu/books/0309071755/html/ Accessed September 11, 2006.
Zaza S, Briss PA, Harris KW, eds. The Guide to Community Preventive Services: What Works to Promote Health? Task Force on Community Preventive Services. New York: Oxford University Press; 2005.
Cochrane Behavioral Medicine Field. Available at: http://www.cochranebehavmed.org/ Accessed September 11, 2006.
Public Health Functions Steering Committee. Public health in America. 1994. Available at: http://www.health.gov/phfunctions/public.htm Accessed September 11, 2006.

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Health Care Reform Issue Paper
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Improving Health Status: Ensuring the optimal health of all Oregonians requires a health care delivery system that treats individuals when they become ill. It also requires a public health system that provides individual and population-based disease prevention and health promotion services to help keep people well. Health care services are primarily provided by private providers, and prevention services — particularly those that are population-based — are the purview of governmental public health, but there is overlap between the two. SB 329 is focused on reforming the delivery of health care services, but it offers an opportunity to bring public health into the reform dialogue. This is important, because health care delivery services will be more effective if public health concepts are integrated into the reformed system. Additionally, a reformed health care system should directly support population-based prevention activities to maximize the potential for keeping Oregonians healthy.

Concept: Expanding access to health care is fundamental to ensuring that Oregonians are healthy. However, research shows that successful reform must include the expectation that health care providers will promote community health, by providing services that go beyond the standard medical treatment of individual patients. To ensure this community-based commitment occurs, the reformed system must include:

- **Basic expectations on the provision of such services;**
- **Incentives or mandates for the provision of these services;**
- **Accountability monitoring as to whether or not these services are provided; and**
- **A system to support providers as they do this work.**

Provider Role: At a minimum, all providers participating in the state's health care reform initiatives should:

- Provide or support population-based health promotion and disease prevention activities within their communities that are modeled on evidence-based practices,
- Implement preventive care service recommendations as specified in *Preventive Care: A National Profile on Use, Disparities, and Health Benefits*, Partnership for Prevention, 2007.
- Adopt the Robert Wood Johnson Foundation Chronic Care Model as the framework for providing health care services to patients. Components of the

model include self-management, decision support, delivery system design and clinical information systems,
- Actively participate in community-based coalitions, including those dealing with specific diseases/issues (such as tobacco use, obesity, injury prevention) and those attempting to increase access and/or improve quality of health care services in their localities,
- Provide outreach within their geographic catchment area to enroll currently unaffiliated, vulnerable individuals into health care service systems, and
- Conduct a self-evaluation and participate in a system-wide evaluation of the number of community-based services provided, services utilized by targeted groups and outcomes achieved.

<u>Systems Support</u>: Health care providers are trained and currently practice in an individual patient treatment model. They will need support if they are to successfully incorporate public health prevention concepts into their work. Equally important, these additional population-based services cannot be implemented unless there are resources to support them. Consequently, the administrative framework of SB 329 reform efforts must include a systems approach that provides:

- Incentives and/or mandates for health care providers to participate in all the activities listed above.
- Technical support that helps providers with:
    - Identifying evidence-based population-based services appropriate for the community being served,
    - Implementing preventive care services and the Chronic Care Model,
    - Coaching on appropriate participation in community-based coalitions,
    - Successful outreach strategies and culturally competent care, and
    - Data analysis for evaluating outcome measures.
- Help in identifying alternative population-based service providers in a community, should a health care provider choose to contract for such services rather than provide them directly.
- A centralized evaluation method to determine the amount of preventive services being provided, relative engagement of health care providers in such services, and outcomes associated with these services.
- Funding for the support, evaluation and direct provision of population-based services.

EXAMPLES

Evidence-Based, Population-Based Health Promotion Activities

- Oregon's Tobacco Prevention and Education Program is a comprehensive, multi-faceted, state-local project that has substantially reduced the number of smokers and consumption of tobacco products in the state.
- School-based dental sealants are an evidence-based practice that can prevent decay among more than 10,000 Oregon children.
- Educational and policy interventions in both primary school settings and recreational/tourist areas have effectively reduced the amount on skin cancer-causing UV radiation exposure.
- Multi-component interventions using both community-wide education and clinic-based education have increased vaccination rates in both adult and pediatric populations.

Effective Clinical Preventive Services:

- 450 Oregon lives could be saved each year if 90 percent of adults took aspirin to prevent heart disease.
- 420 Oregon lives could be saved each year if 90 percent of smokers who are advised by a health professional to quit smoking were offered medication and other assistance.
- 140 Oregon lives could be saved each year if 90 percent of adults age 50 and older were up-to-date with recommended colorectal cancer screening.
- 120 Oregon lives could be saved each year if 90 percent of adults age 50 and older were annually immunized against flu.
- 37 Oregon lives could be saved each year if 90 percent of women age 40 and older were screened for breast cancer every two years.
- School-Based Health Centers are an example of an evidenced-based practice that increases access to and utilization of clinical preventive services.

Chronic (Comprehensive) Care Model Successful Applications:

- The RWJF Chronic Care Model, evaluated by RAND, has:
    - Significantly decreased the risk of cardiovascular disease among patients with diabetes;
    - Resulted in patients being more knowledgeable, more compliant with treatment, and having 35 percent fewer hospital days; and
    - Made it more likely that patients with asthma receive appropriate therapy.
- The U.S. Department of Health and Human Services Clinical Practice Guideline, The "5 A's" for Brief Interventions (Ask, Advise, Assess, Assist,

Arrange), when used by health care providers, has improved smoking cessation rates for pregnant women.

Successful Community-Based Coalitions:

- The 100 Percent Access Coalition, a Lane County public/private partnership, provides outreach and enrollment into the Oregon Health Plan, culturally competent medical homes, affordable prescriptions, referrals to specialty care, chronic disease management, and care coordination.
- The Central Oregon Health Collaborative, a public/private partnership involving Deschutes, Jefferson and Crook Counties, is working on creating a medical home and coverage for low-wage workers, wellness programs for employers, and community gardens.
- Issue-specific prevention programs sponsored by community-based coalitions include older driver education, child safety seat education and distribution, infant safe-sleep guidelines, depression and suicidality screening and assessment, and domestic violence screening and assessment.

Effective Outreach Initiatives:

- David Olds' outreach and home visiting services program for high-risk pregnant women and their children has documented successful outcomes including:
    - 56 percent fewer doctor and hospital visits due to childhood injuries,
    - 25 percent reduction in cigarette smoking by mothers during pregnancy,
    - 48 percent less incidence of child abuse and neglect through children 15 years and younger,
    - 69 percent fewer convictions of nurse-visited children through 15 years and younger, and
    - 83 percent increase in workforce participation by low-income, unmarried mothers.
- **AFIX** is a strategy to improve immunization coverage that is directed at provider groups. It involves **A**ssessing immunization records, **F**eedback of results to the provider, offering **I**ncentives such as rewards or praise, and e**X**change of results to stimulate providers to identify and implement improvement strategies.

Investing in Oregon's Health Care Safety Net

Opportunities and Challenges

Safety Net Advisory Council

Staff support – Office of Health Systems Planning (HSP) Office of Health Policy and Research (OHPR)

Members of the Safety Net Advisory Council

Priscilla Lewis, Co-chair – Providence Health Systems
Craig Hostetler, Co-chair – Oregon Primary Care Association
Bill Thorndike – Medford Fabrication
Jackie Rose – Oregon School-based Health Care Network
Tom Fronk – Benton County Health Department
Vanetta Abdellatif – Multnomah County Health Department
Scott Ekblad – Office of Rural Health
Abby Sears – Our Community Health Information Network (OCHIN)
Ron Maurer – State Representative
Beryl Fletcher – Oregon Dental Association
Jim Thompson – Oregon Pharmacy Association
Tracy Gratto – Coalition of Community Health Clinics
Steve Kliewer – Wallowa Valley Center for Health and Wellness
Matt Carlson – Portland State University

Who are Oregon's Health Care Safety Net Providers and what do they do?

Safety Net Providers represent a key building block in a re-engineered health care delivery system

The safety net plays an important role in providing access to primary care for very low-income, uninsured, Medicaid and Medicare clients across the state. By definition, the mission of the "safety net" is to serve those who face a variety of barriers to care including economic, geographic or cultural and racial. As a result, the safety net represents an important element of Oregon's primary care capacity.

In addition to being a key access point for many Oregon's most vulnerable and as a result of their mission – the safety net has valuable, demonstrated expertise in serving these populations and over the past two decades has demonstrated a willingness and ability to innovate and drive transformation in the delivery of care.

Oregon's health care safety net –

- Providing primary care homes
  - for those not yet determined eligible and enrolled in a health plan
  - for those enrolled in a health plan contracting with safety net clinics
  - for those who face barriers to care as noted in the Safety Net definition
- Providing primary care options that fit the needs of certain populations and communities
- Sole providers in isolated rural areas and certain communities
- The delivery system's "insurance" against downturns in the economy
- A laboratory for trying out new approaches to care

Safety Net Advisory Council - Presentation to the Oregon Health Fund Board

Background

Oregon's Health Care Safety Net:

- Federally Qualified Health Centers (FQHC)
- Isolated Rural Health Facilities (IRHF)
- School-based Health Centers (SBHC)
- Community Sponsored Clinics (CSC)
- Local Health Departments (LHD)
- Indian Health Service Clinics (IHSC)
- Hospital Emergency Departments
- Private practices

A Community's Response
Oregon's Health Care Safety Net is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous care. Oregon's safety net is comprised of public, private and not-for-profit organizations that provide health care services to uninsured, underinsured and vulnerable persons throughout the state.

Linking these different sectors is a mission or a mandate to provide health care services to people who are in need. Oregon's safety net community shares many strengths and challenges in common but also has a great deal of variation in patients served, revenue sources and business models. Some clinics are private not-for-profit and sponsored by the community; others have some federal funding but can be either not-for-profit or county government operated; still others receive state funds. This complexity presents both flexibility and challenges for policy makers.

A Critical Piece of the Health Care Delivery System
Every day, Oregon's safety net providers have stories to share about people who, without their services, would otherwise go without medically necessary care. Many Oregonians have limited access to primary care and delay seeking help until they are seriously sick or hurt.

Our over-burdened emergency departments have stories to share about patients whose only outlet for medical care is through their doors. These stories describe patients whose conditions could more appropriately be treated in a primary care setting or illnesses and injuries, which could have been prevented or ameliorated if the patient had access to care sooner.

Ideally, the image of a net captures nicely the role of the health care safety net; able to stretch or contract in response to Oregon's economic or health policy climate. In recent years, however, demand for safety net services has risen dramatically requiring the net to expand beyond, in many cases, available resources. Regardless of type or location, safety net providers have stories to share about the challenges they confront with limited resources, increasing demand and escalating health care costs.

This increase in demand is largely driven by the growing number of uninsured individuals or those unable to find a provider willing to receive Medicaid/Medicare reimbursement. However, it is not simply the escalating financial challenges that determines who utilizes Oregon's safety net clinics. Many patients are also struggling with psycho/social barriers. There are a growing number of patients requiring mental health and substance abuse treatment; many are challenged with homelessness or live in geographically isolated areas where access to comprehensive health care services is inadequate.

Oregon's racial and ethnic makeup is becoming increasingly diverse and the safety net serves a disproportionately high percentage of diverse populations as well as individuals living below 200% of the FPL. Safety net providers are seeing greater numbers of patients overall and those patients seeking care are both sicker and are presenting with more complicated conditions.

A Good Investment

If our hospital emergency departments are the "canary in the coal mine" for our health care system, then our safety net clinics help light the way for many who otherwise would not receive the care they need. In addition to responding to this critical need for access to basic health care services, however, Oregon's safety net clinics also serve as laboratories for innovation and experimentation within the delivery system. Care coordination, proactive management of chronic diseases, integration of behavioral and primary care and primary care medical home models have all been launched as pilots within the safety net.

Many safety net clinics are uniquely positioned to redesign the way care is delivered to the populations they serve. These clinics are attuned to the needs of some of the state's most marginalized patients and have developed creative and comprehensive approaches to meeting these needs.

While the safety net has demonstrated itself to be a favorable environment in which to experiment, it is important to ensure that expectations for re-design are compatible with both the needs and the resources of the clinic and the community.

Individualized features of different safety net sectors must be recognized as those that have emerged to best meet the needs of the community. This diversity of sector type, governing structure and financing is both the greatest asset and a confounding element within the safety net - each sector, indeed each clinic, is unique but shares similar challenges with all other safety net clinics across the state.

Because of its range of models, the safety net is complex and difficult to describe uniformly. Nevertheless, it is vital that decision makers utilize a systemic approach for developing supportive policies. Oregon's safety net system is both a critical component of the current system and a place to gain valuable insights on innovative approaches. These lessons can help to inform the process of building a more affordable, effective and sustainable healthcare delivery system for all Oregonians.

The Safety Net Advisory Council advances the following recommendations targeted at **Funding, Critical Tools** and **Workforce** as ways to significantly invest in the safety net. Each of these components are linked and will inform the overall stability of Oregon's health care safety net system.

Safety Net Advisory Council

Policy Recommendations

Presented to the Oregon Health Fund Board and the Oregon State Legislative Assembly

1. Stable Funding

Establish the Core Health Safety Net Stability Investment Fund.

- Assist clinics in financial trouble
- Assist with strategic investments to maintain infrastructure
- Invest in new site development or expansion
- Link funds to technical assistance to address specific organizational issues/challenges

2. Critical Tools

Electronic Health Record Adoption across the Safety Net

- Provide systematic approach to EHR adoption across the safety net
- Assist with the capital-intensive start-up and ongoing maintenance and technical assistance costs.
- Provide better patient and treatment information and improve the safety, quality and efficiency of care

3. Workforce

Implement innovative approaches to meet safety net workforce needs:

- Rural Locum Tenens Program
- Flexible community health workforce options
- Oregon Health Services Corps (Loan Repayment)
- Updated Tax Credits
- Provide an increased pipeline of midlevel providers to rural communities.

SAFETY NET ADVISORY COUNCIL (SNAC)

Revised –2/11/08

Policy Recommendation – STABLE FUNDING

Concept Summary:

Establish the Core Health Safety Net Stability Investment Fund.
Establishes a fund to address safety net system needs when there is a statewide downturn in the state and in local economies including but not limited to assisting clinics in financial trouble, making strategic investments to maintain safety net infrastructure, and investing in new sites or expansions where gaps are clearly identified.

This investment fund provides a source of capital in times of need including bridge funding and meeting cash obligations with technical assistance as a component to assist organizations with specific strategies to address underlying issues.

It provides a source of capital for expansion or improvement including facilities expansion or improvement, infrastructure not tied only to economic downturns.

Issue it addresses: *Core safety net providers as defined in SB 329*

- ***Section 2 (2)*** *"Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, and that has a mission or mandate to deliver services.... serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare...*

- ***Statement of Principle:***

  Section 3 (16) *The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.*[i]

Rationale

Currently no public fund or financing mechanism exists to help assure this principle is realized. There has been no systemic or statewide investment strategy in the safety net. As a result, the safety net has evolved organically responding to a variety of circumstances across the state over a number of years. This has resulted in both strengths and challenges; the good news is that a network of core providers has evolved to meet the needs of different communities. The challenge is that public policy has limited tools with which to support critical community investment, expand its impact, and to help assure its strength and viability. The Core Health Safety Net Stability Investment Fund would provide such a tool. Recent recession talk and the safety net's inverted relationship to a downturn in the economy underscores the need for such a tool.

How it would work:

Core Safety Net Investment Model:

- "Grow" investment fund sufficient to provide $1m in grant funds for year 1, $2m for year 2, $3m for year 3 and sustained at $3m per year

- Fund priority safety net investments from interest
- "Fund" investments also from low interest loans to safety net entities who "repay" revolving loan fund
- Link funds where possible with foundation initiatives to magnify impact
- Include technical assistance role to address issues that are beyond immediate available of cash ie, financial management, business planning, etc.
- Link to matching funds where feasible
- Administered by DHS with necessary expert staffing in house and/or contracted in regard to loan component, guidelines and administrative rules and with oversight by Safety Net Advisory Council with addition of necessary financial expertise
- Or administered by foundation or other independent entity with necessary programmatic and financial skills

Priority Investments:

- Focus on core investments in safety net infrastructure for the provision of primary care, oral and behavioral health
- Identify and assist clinics experiencing financial difficulty
- Identify communities or clinics to establish sites where gaps exist and a feasible long term plan is adopted
- Assistance with recruitment and retention of workforce and/or the use of transformative technology
- Assistance with availability of pharmaceuticals
- Where commitments to providing documentation of outcomes over time are present
- Where matching funds are present
- Where linkages are established with health districts, public health departments, collaboratives, hospitals, other providers, and health systems as appropriate to the location
- Where other existing programs such as tax credits and loan repayment are utilized
- Where commitments to a diverse workforce are present and realized within the limitations of location

Building The Investment Fund - Options for creating the revolving fund include but are not limited to:

- Legislative appropriation
- Public bond
- Partnership between foundations, community funds, health systems, and insurers, and state with contribution to retire bond or establish fund

- Model "adoption" process whereby insurers and health systems adopt sites or clinics for a limited time period to assist them in repaying loans

Anticipated outcomes:
Greater financial stability for the safety net as a whole and in specific communities. Improved safety net ability to respond to changes in the economy. Gaps in the safety net addressed. Improved core infrastructure among safety net clinics. Shared responsibility across key stakeholders and communities. Stronger component of the roadmap.

Cost and how it might be financed:
"Grow" investment fund sufficient to provide $1m in grant funds for year 1, $2m for year 2, $3 for year 3. In addition loans would be made once the fund was sufficiently established. Investing at this level would make a significant difference in the stability and viability of the safety net over time. Expertise in modeling the size of the fund necessary to achieve this rate of grant and loan allocation is needed.

[i] Enrolled Senate Bill 329 – 74th Oregon Legislative Assembly – 2007 Regular Session

SAFETY NET ADVISORY COUNCIL (SNAC)

Revised 12-12-08

Policy Recommendation – CRITICAL INFRASTRUCTURE TOOLS

Concept Summary: *

Address ***barriers to safety net electronic health record adoption.*** Provides alternative mechanisms to fund and assure high safety net adoption rate and optimum application of electronic health technology. This recommendation proposes ***three possible strategies***. They may be adopted individually or in combination. They include an Electronic Health Record fund established by legislative appropriation, state and federal partnership, adoption of a shared cost or utility like model to cover adoption and maintenance. This approach will improve quality of care; provide better information for providers and treatment for patients, greater efficiency and coordination across the delivery system and improved ability to monitor public health.

Background:

With the passage of Senate Bill 329 Oregon committed itself to assuring access and coverage to Oregonians and to reforming the delivery system to help assure access, quality, and safety as well as controlling the rate of cost. There is growing conjunction of federal policy and emerging state policy regarding Health Information technology. There is developing federal policy regarding standards for interoperability and both a state and federal focus on privacy issues.

Oregon has recently been presented with two significant opportunities to develop the necessary health information technology infrastructure. The state received over $5 million through the Oregon Medicaid Transformation Grant to develop a personal health record model for the Medicaid population. Additionally, Oregon was awarded over $20 million by the FCC to fully implement broadband connectivity for rural areas.

In essence the message is clear – Oregon and the nation are moving toward greater readiness to implement health information technology as a key tool to serve the broader goals of access, quality, safety, improved health and cost reduction. *The safety net has a key role to play in each of these initiatives and policy makers can assure it has the necessary resources to do so.*

It must be underscored that while this is new territory for most, it is particularly unfamiliar to many safety net providers. Furthermore, there is no way to ensure that the investment will be no-risk or even low-risk to begin with. Health information technology is capital intensive and will require both a significant investment up front as well as on-going technical support.

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* *A note on workforce* – it is clear that we need an "e" workforce to go along with e-health technology and its associated implications for clinical practice if we are to realize the promise of health information technology. *It is recommended that the Oregon Health Workforce Institute assess the state of e-health related needs* and work with education institutions and employers, to assure the availability of individuals with necessary skills, certifications, and degrees.

The Safety Net Advisory Council strongly urges the state to engage expert analysis of the electronic health record/personal health record funding options to review the literature and assist with developing the most viable funding option. With that caveat, the SNAC suggests the following alternate approaches.

Summary of Alternative Funding Strategies: (Consider and adopt singly or in combination)

- Create a ***safety net EHR investment fund*** through a legislative appropriation matched by local collaboratives, health systems, and insurers sufficient to capitalize an 80% safety net adoption rate. Also include low interest loans, revolving loan fund for future adopters, initial pay for performance steps

- ***State and federal partnership*** leveraging Medicaid and Medicare dollars to invest in clinic network models to bring down cost and support adoption through volume purchasing, subsidies for acquisition, and integrated quality improvement and patient safety strategies

- Define an ***Oregon style "utility" model*** for funding the cost of EHR adoption, beginning with the safety net and expanding to other parts of the health system. Incorporate technical assistance, quality improvement, patient safety, and primary care renewal elements.

Rationale:

- **Across all providers** – hospitals ahead of curve, health systems clinics 52.2% adoption rate, solo clinician practices 19.3%, 2-4 clinicians 25.1%
- **Safety net** – Public and FQHC clinics (20.4%)
- by each safety net sector – FQHCs 29.6%, SBHC in Public category 20.4%, RHCs likely less than 15% (arbitrary percentage)
- Churning of individuals on and off Medicaid and across health plans and providers
- the need for more systematic approaches to comprehensive EHR adoption
- Government, federal, state, and sometimes local obtain and/or leverages resources for those providers without the margin to invest
- Important to identify critical criteria for a comprehensive funding strategy
- Potential for some strategies to help facilitate adoption across the entire system
- Some resources and solutions unique to the safety net are needed

Safety Net:

- Includes school based health centers (SBHC), Federally Qualified Health Centers (FQHCs) (otherwise known as Community Health Centers), Rural Health Clinics especially those known as Isolated Rural Health Centers (IRHC), and volunteer clinics

- Together these clinics provide services to the uninsured and represent a significant part of Medicaid capacity
- Increasingly a larger percentage of Medicare clients, with the exception of SHBCs, will be seen by those clinics who currently comprise the core safety net
- While the primary emphasis of this analysis and recommendations is on the core safety net it is important to recognize that many small to medium offices also provide some level of care to a similar population
- Some EHR solutions or strategies may be focused on the core safety entirely or in other cases scale may suggest integrated solutions across a broader portion of primary care

Barriers to adoption:

- **Across all providers** – initial system cost, initial temporary productivity loss, risk of failure, ongoing cost, confusing array of products, lack of expertise, ok with the way it is, someone needs to lead the charge
- Lack of state HIT roadmap "target end-state architecture vision – in process but not at "use" stage
- **Safety net specific** – Generally similar especially regarding cost and productivity loss but with much less income and operating margin then private sector, less access to capital
- Without the same ability to generate additional margin, safety net provider funding strategies involve financing EHR through reduced services to uninsured Oregonians
- Within the safety net, not all "lines of business" are equal: – FQHCs (and associated SBHCs) have the greatest exposure to EHR through OCHIN (an Oregon based clinic controlled network); SBHCs not associated with FQHCs have limited exposure and resources. RHCs especially isolated rural ones are concerned with the full range of barriers and limited time and resources to attend to EHR. Volunteer and free clinics, in addition to other barriers may face the challenge of recruiting additional volunteer and in-kind resources to maintain an EHR. In addition, ability to adopt inversely related to percentage of uninsured clients served.

Current approaches to funding

- **Across all providers** – self-finance from profit or operating margin, loans
- **Safety Net** – federal and foundation grants, capital fund drives, loans, county general fund (for those that are also FQHCs), collaborative approaches such as OCHIN, reducing capacity to serve
- Federal grants relating to HIT adoption
- Note limitations of grants
- Note uneven resources and fragmented strategies across the safety net
- Pay for performance at early formative and explorative stages
- Lack of incentives slows adoption rate across all primary care

Cost and Potential Financing

Suggested criteria for consideration of options:

- Broad based stakeholder participation – purchaser, insurer, consumer
- Approach addresses needed changes in clinical practice to assure optimum outcomes from EHR implementation
- Targets penetration percentage across safety net and primary care
- Linkages to other EHR related initiatives are established
- Provides key elements for systemic solution
- Provides solutions that may be applied retroactively, to include early adopters
- Not overly complex
- EHR products are certified
- Concepts include technical assistance for EHR selection
- Concepts provide technical assistance for optimizing EHR utilization
- EHR selection and implementation is closely linked to clinicians and evidence based clinical practice
- Concepts assure EHR is integrated into quality improvement and patient safety practice
- Concepts assure Rural EHR network capacity across large rural areas of the state and multiple small clinics

Alternative Funding Approaches:

A. Safety net EHR fund

- State incentive package or menu including grants, low interest loans, revolving loan fund for future adopters, initial pay for performance steps
- Cost for 80% safety net adoption rate over 2 years estimated
- Cost burden is shared by state general funds, purchasers/insurers/health systems share, and local partners share
- Legislature appropriates EHR Safety Net adoption fund
- Other purchasers contribute to grant and/or loan pools
- First priority for grants for isolated rural areas and other entities with very limited access to capital
- Minimum requirements for access to fund determined including pay for performance indicators
- Grants and loans fund amount based on loans sufficient to accomplish desired adoption rate
- No interest loan repayment over 5 years for individual adopters using the loan component

B. State and Federal partnership

- DHS/CMS/HRSA partner to model integrated safety net EHR funding strategy. Per member per month cost is determined for Medicaid and uninsured individuals and partners share cost proportionately, Medicaid for Medicaid, and DHS and HRSA for uninsured. Incorporating set of expectations for quality improvement and EHR adoption, e.g. use of health center controlled networks and/or application service providers could be additional elements of such collaboration – See HHS description of demonstration using Medicare wavier authority as a potential model for Medicaid. (http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/EHR_Summary.pdf)
- Partners set adoption target and primary care renewal related targets
- Partners establish leveraging linkages between Medicaid Program, Medicare Program, Medicaid Transformation Grant, FTC grant, and Intergovernmental Transfers, alternatives to PPS, or other mechanisms
- Identify statewide infrastructure to facilitate EHR adoption and maximize benefit of group purchasing such as health center controlled networks and/or application service providers to bring down cost and support adoption through volume purchasing, subsidies for acquisition, implementation assistance, and integrated quality improvement and patient safety strategies

C. Oregon EHR Utility

Key principle – access to and funding for electronic health technology could be on a basis similar to water, fuel, and other similar resources needed by the public at large

- Elements common to utility services, according to M.A.Rappa* include necessity, reliability, usability, utilization, scalability and exclusivity although in various public models exclusivity may be not be utilized in favor of a more competitive arrangement.
- utility operates and maintains access to the needed resource and distributes cost across all "users" including initial implementation and ongoing costs or only initial implementation costs
- The ultimate beneficiaries are low income and uninsured Oregonians. In this model stakeholders act on their behalf providing the initial necessary capital with both the stakeholders and patients deriving benefit
- Concept is scalable to the safety net and based on success could be expanded to include all 2-10 person offices, and beyond that to all health systems

C(i) Utility Adoption Goals

- Statewide goal could be set 80% of all core safety net providers and/or broader Medicaid primary care adoption of EHR within 2 years
- Implementation costs for 80% safety net adoption rate within 2 years can be estimated at_____.
- Implementation costs for 80% adoption by all Medicaid providers within 2 years can be estimated at_____.

C(ii) Utility Core Structure

- Initial capital fund financed by a commercial bank – at XX dollars
- Entity selected to manage distributed payments and services payments on line of credit
- Cost is distributed across Medicaid, Medicare (?), private insurers, and clinics on a per person per month basis including costs for the uninsured
- All funding entities participate in governance body (non profit or semi-independent stage agency, e.g. EHR commission?)
- Patients/consumers also participate on governance body
- Initial capital acquisition costs distributed over 5 year pay-off period?
- Entity provides group of EHR transformation services including technical assistance at implementation, implementation and optimization of primary care home care management elements and related patient safety and quality improvement elements.
- Participating providers agree to implement A Certification Commission for Healthcare Information Technology (CCHIT) certified EHR
- Participating providers agree to adopt and implement quality measures as determined by project governance
- Initial focus on safety net then expansion to all primary care
- Safety Net to goal adoption cost estimate and utility related income estimate needed
- Medicaid to goal adoption cost estimate and utility related income estimate needed

Anticipated outcomes of EHR adoption:

- "The driving force for adopting advanced health information technologies is the potential it provides for improving the quality and safety of health care." From a report produced by Office of Health Policy and Research in 2007 **Potential Impact of Wide spread Adoption of Health Information Technologies on Oregon Health Expenditures**
- "The net potential savings in Oregon from the widespread adoption of advanced health information technologies are between $1.0 and $1.3 billion annually. This level of savings would yield a net reduction of 4.3% to 5.9% on Oregon's health expenditures. Such savings are possible within 12 years with aggressive implementation efforts."
- "For uninsured patients the payers are predominantly the physicians, **safety net clinics** and hospitals that end up financing the uncompensated care they provide. When services are avoided, the costs of uncompensated care rendered to the uninsured absorbed by physicians, hospitals and other providers would be lower."
- **Policy makers** – data to make good policy, less cost, greater value
- Good products combined with good practice, quality improvement, safety, and technical assistance leads to:
- **Patients** – better care, safer more affordable care, and information on their care

- **Providers**- patient and treatment information when needed and greater capacity to manage care on behalf of their patients
- Create the groundwork enabling movement of patient information between providers **(Health Information Exchange)**
- **Public health** – monitoring and improving population health

SAFETY NET ADVISORY COUNCIL (SNAC)

Revised 2-12-08

Policy Recommendation WORKFORCE

Concept Summary:

Rural Locum Tenens Program*

Public Policy Goals:

1. Provide temporary coverage to rural healthcare providers during vacations and continuing medical education
2. Sustain medical and dental service delivery when local providers are away from their respective rural communities
3. Provide longer term medical and dental services to rural communities without medical care services or those that have lost medical care services
4. Expose medical residents and OHSU faculty to the realities and opportunities of rural medical and dental practice

Taken from the Latin "to substitute for", locum tenens providers are physicians who provide temporary medical services for a specific length of time. This can vary from a few days to allow for vacation or continuing medical education, to several months for medical leave or interim coverage between providers.

The Rural Locum Tenens Program seeks to assist rural communities, physicians and dentists by providing reasonably priced, high quality, reliable relief coverage so that these providers may have time away from their practices for continuing education, vacation, health or other personal reasons or family time. In addition this model may provide longer-term services to communities without medical or dental care and may be linked to supervision of mid level networks in certain areas of the state.

Issue it addresses:

Multiple factors jeopardize adequate healthcare coverage for rural communities in Oregon and nationwide.

- Inadequate number of medical and dental school positions (Oregon and nationally)
- Inadequate number of residency positions (Oregon)
- Declining enrollment of students from rural backgrounds (nationally, somewhat less so in Oregon)
- Declining student interest in primary care specialties (nationally, less so in Oregon but still a problem)
    - Rapidly rising debt load limits interest in lower paying specialties and areas among health profession students (medical, nursing, allied health)
    - Low reimbursement rates for primary care specialties
    - Admissions policies that favor students unlikely to go into rural practice

* Concept initially developed by a work group of the Oregon Health Workforce Institute – SNAC is appreciative of their effort

- Declining state support for the public and education missions of OHSU (Oregon is 45th out of 48 in per student funding among medical schools who receive public funding)
- Changing demographic of medical school graduates
    - Approaching 50% women
    - More dual career families (w/spouse needing to be in urban area for job)
    - Trend toward medical careers with less call, more scheduled hours
    - Less willingness to commit to long-term practice location
    - Increased number of job changes over career
    - More employed physicians, no desire to run a small business
- Rural physician population older than urban population
- Rural population older, and aging faster than urban
- More dependent on Medicaid/Medicare, more uninsured in rural leading to reduced reimbursement and marginal profitability of rural practices
- Vulnerable infrastructure in rural communities (schools, social, economic)
- Inadequate loan reimbursement/forgiveness opportunities

Due to these and other factors, attracting physicians and dentists to live and practice in rural communities is getting harder. Graduating physicians find they can have less call, better income, and better opportunities for spouse and children by choosing non-primary care, urban jobs. This is compounded by the increased workload that then falls to those who do choose to go to rural areas.

Rural practices and hospitals have difficulty covering the needs of their community on a 24 hour, 7-day per week basis due to the limited numbers of providers present in the community. Many rural communities do not have sufficient medical staff to allow physicians or dentists time away for vacation, continuing education and other important activities to prevent burnout and increased turnover. In addition, the broad scope of practice inherent in rural practice can make finding temporary coverage difficult or prohibitively expensive. Commercial locum tenens agencies charge fees substantially higher than can be afforded by rural physicians, whose incomes and practice revenues are not sufficient to support those costs.

How it would work:
Utilizing OHSU faculty, fellows and residents will make available a high quality, well-trained workforce for rural communities; provide coverage at a lower cost with broader scope of practice than is often available from commercial sources. Benefits to OHSU and the faculty are enhanced practice opportunity and maintenance of skills for participants, additional income opportunity to departments and physicians, and the opportunity for young physicians and dentists to experience rural life and practice without an initial full-time commitment (which may enhance recruitment opportunities for these communities).

As the only current academic health center in Oregon, OHSU holds much of the responsibility for training physicians and dentists to meet the needs of all Oregonians. Faculty, fellows and residents can participate as locum tenens providers on a part-time

temporary basis as part of their regular duties, or as extra income producing work. Because OHSU already verifies credentials of its physicians, communities do not sustain any extra expense to perform these essential tasks. Academic health center based programs exist in other areas, such as University of Kansas and University of New Mexico.

Anticipated outcomes:

For rural physicians and dentists:

- Affordable practice relief for vacation, continuing education or illness
- Supplemental assistance during busy times
- Ability to keep office open and staff employed
- Revenue produced when office would otherwise be closed
- Recruitment

For locum tenens physicians and dentists:

- Opportunity to experience rural practice without having to commit long term to one location
- Income to relieve financial burden
- Skill enhancement
- Flexible scheduling and part-time work availability

For rural communities:

- Ability to obtain 24 hour/7 day medical services
- Recruitment
- Economic development, keeping medical care in the community
- Opportunity to showcase community to potential physicians and dentists.
- Infrastructure development

For OHSU:

- Support for rural communities
- Training opportunities for faculty, fellows and residents
- Academic faculty skill enhancement and maintenance
- Support for community physicians who provide teaching service to OHSU

Cost and how it might be financed*:

Fees generated by the program will provide the majority of the funding. To keep fees low enough to be helpful, however, there is a need for additional support. The Area Health Education Center at OHSU received grant funding for program planning and development. Additional funds will be sought from the Legislature for start up costs, administrative overhead, and technical assistance for communities seeking locum tenens services. Funds will also be sought to provide a program subsidy for services provided in medically underserved areas. These funds, if obtained, can be used to sustain the first 2-3 years of start up for the program. A sliding scale fee will be developed in order to keep the costs low enough to be feasible.

* These cost projections were undertaken prior to the inclusion of dentists into the locum tenens program and will need to be re-thought to incorporate this addition.

The start-up costs for a locum tenens program at OHSU would be $1 million for the first biennium. On-going funding will decrease once the program is up and running as fees and revenues generated by the provision of medical services will offset most program costs. There will likely be the need for $500,000 of state funding per biennium to subsidize locum tenens services to communities that cannot cover the costs (e.g. rural communities with no local hospital).

Concept Summary:*

Support of Physician Assistants and Nurse Practitioners to Meet the Rural Primary Care Medical Needs of Rural Oregon

Public Policy Goals:

1. Recognize the reality that the limited present and future supply of primary care physicians will have added adverse impact to rural Oregonians.
2. Provide an increased pipeline of physician assistants and nurse practitioners educated to provide primary care services in rural communities.
3. Due to the shorter length of training, be able to quickly increase the supply of qualified primary care providers for rural communities.
4. Utilize existing public health or other community infrastructure to provide a "home" for supervising physicians
5. Link effort to achieving specific health outcomes through training of mid-levels in integrated primary care and public health approaches

Provide targeted investments in existing physician assistant and nurse practitioner educational programs to provide incentives for the recruitment of students from rural areas through pre-awarded loan forgiveness (pending successful completion of the training program) and expanded rural rotations for these and other students.

Provide incentive funds for local health departments or other entities to hire a physician, supporting up to four to eight physician assistants that would serve the more remote parts of the participating counties or regions. Physician assistants are a good fit for remote, low population communities that are unable to attract or support a physician. If two or more counties partnered in such an arrangement it would likely be more sustainable over time. This local network concept could entertain other partners such as rural hospitals to help spread the cost and contribute to sustainability. Formation or utilization of an existing health district might provide a framework for this relationship.

This employment arrangement may also relieve the burden of cost of the physician's malpractice coverage, as s/he would be the employee of a public agency. Note: Tort Liability situation is up in the air as the result of the recent State Supreme Court decision

* Note: This concept was originally developed by a rural health work group of the Oregon Health Workforce Institute (OHWI). It has been modified in some ways to further clarify the concept. The Safety Net Advisory Council appreciates the OHWI commitment to developing ideas to address workforce needs.

that the tort liability cap is too low. This is an issue that will have to be addressed and is broader in implication than this particular proposal.

While nurse practitioners and certified nurse midwives do not require the supervision of a physician in order to practice in Oregon, that supervision is required to comply with federal Rural Health Clinic (RHC) regulations. The same arrangement could be utilized for nurse practitioners and certified nurse midwives working in rural health clinics. Similar partnerships to those noted above in regard to physician assistants could be developed. The health district model could facilitate a regional approach to addressing rural workforce needs.

This model could be further developed to link the work of community health workers, community paramedics and public nurses into a coordinated team to assure the provision of necessary care and health promotion and preventive services.

Issue it addresses:
This concept would address the economic challenges faced by rural areas of the state in providing for health and healthcare related services. It would help address some of the challenges faced by rural health care and rural public health.

Oregon has been one of the national leaders in the training, licensure and deployment of physician assistants and nurse practitioners. Presently approximately 650 physician assistants are licensed in Oregon. Of these, approximately 300 practice in primary care throughout the state, one-third of who are working in the Portland metropolitan area. There are presently approximately 2,750 advanced licensed nurses (nurse practitioners, certified nurse midwives, Certified Registered Nurse Anesthetists) actively licensed in Oregon.

Several national trends indicate a future significant shortage of primary care physicians:

1. Inadequate numbers of medical students in the educational pipeline to meet the projected needs of a growing and aging population and to replace physicians who will retire in the coming ten years.
2. Fewer and fewer medical students choosing primary care specialties due to many causes such as lower income and demanding life style.
3. The time lag of at least 8 years (four years of medical school and four years of residency) to add additional primary care physicians.

Communities often shy away from considering physician assistants due to the additional cost of the supervising physician.

How it would work:

- County wide or multiple county public health commitment is made to provide the home for network supervision
- Similar commitments are made if rural clinic, rural hospital or other entities commit to network supervision

- Entity partners with educational institutions to provide options for rural rotations and other approaches to enhance the likelihood of placement in their communities and education program target is established
- Educational institutions recruit and enroll
- Area Health Education Centers participate through health career approaches at the elementary and secondary level
- Office of Rural Health links loan repayment program to students at beginning of program and monitors relationship
- Steering committee comprised of stakeholders provides a home for the overall strategic partnership
- Effort is evaluated by external parties against predetermined outcome indicators

Cost and how it might be financed:

1. Legislature provides targeted investment appropriation to existing physician assistant and nurse practitioner educational programs to facilitate the recruitment of students from rural areas and to expand rural rotations.
2. Funds are added to loan repayment program to address commitment provided to recruited students

http://www.ohsu.edu/ohsuedu/outreach/oregonruralhealth/providers/upload/loan-repayment-faq.pdf

3. Legislature provides matching implementation funds to encourage local health departments to participate and provide the necessary supervision and coordination
4. The deployment of physician assistants and nurse practitioners to rural communities comes with the added costs of paying for a supervising physician and his/her malpractice exposure costs.
5. Cost is shared by legislature through its appropriation for loans and other incentive costs, public health in-kind and general fund costs or health district revenue, and other community participants
6. State total cost participation is limited to initial four year period and extended another four years pending evaluation activity
7. State participation is front loaded and tapered off over the life of the project with potential longer term commitment limited to education appropriation and incentive funds for new areas of the state
8. Cost categories include loan repayment and/or forgiveness commitments, mid-level supervision, education institution recruitment funds, Area Health Education participation, technical assistance from Office of Rural Health or other sources
9. Cost to be projected

Anticipated outcomes:

- Additional mid-levels would help address rural workforce needs
- Educational institutions would increase the flow of trained mid-levels in the pipeline and would have confidence in the availability of resources to make this happen

- The cost burden would be distributed across more entities and limiting the burden on any single entity
- Effort would be linked to identified health outcome and access indicators

Concept Summary: *

Oregon Health Services Corps (OHSC).

Strengthen Oregon's Recruitment and Retention Tool Chest through the implementation of an Oregon Health Services Corps (building on the existing limited loan repayment program) making it available to the workforce communities the safety net depends on: physicians, mid-level practitioners, dentists and dental hygienists, and behavioral and mental health practitioners including but not limited to psychiatrists, psychologists, social workers, and treatment specialists. Provide a high level of coordination and integration with other programs addressing workforce needs. This recommendation will provide resources for communities, helping them to compete for available individuals regionally and nationally. This program should be seen as a **companion to the Tax Credit program** described in another recommendation brief. Both programs are part of Oregon's recruitment and retention tool chest.

Public Policy Goals:

Provide a sustainable supply of qualified health professionals to underserved Oregon communities to maintain and improve the health of the community while contributing to economic development.

Issue it addresses:

The loan program was originally created in 1989 although awards were not made until 1994. Since then 122 health professionals have been awarded loan repayment. Of the 122 38% are physicians, 38% are nurse practitioners, 22% physician assistants and 2% are pharmacists (added in 2005). Dentists were added to the program in 2007; the first opportunity for a dentist to be awarded loan repayment will be in 2008. Of the 122 awardees, 20% are currently receiving payment and 38% have fulfilled their obligation and completed the program and 42% either declined or forfeited their award. **Funding remains at $400,000 per biennium**, the level originally appropriated in 1989 **and** with the additional eligible professions added.

Given projected workforce needs the amount appropriated, the amount available for each health professional, and the range of health professionals included is insufficient to attract the range of workforce needed. Loan repayment and related support services are not generally available to other necessary parts of the workforce. That includes behavioral health practitioners other than those covered above and dental hygienists.

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*Note: This concept follows closely but not exactly recommendations developed by a Rural Health Policy Work Group staff by the Oregon Health Workforce Institute. The Council appreciates the work of this group and its focus on an area of critical need.

The federal government makes loans and scholarships available through the National Health Services Corps. Physicians, nurse practitioners, physician assistants, dentists, mental and behavioral health professionals, certified nurse midwives, and dental hygienists are eligible for loan repayment or a limited number of scholarships based on practice site scores. They must agree to serve in underserved areas and fulfill a minimum service commitment. Currently Oregon has about 60 practitioners who benefit from this program. Federal funds are limited and must be distributed across the 50 states. Available loans are far fewer then the need nationally and locally. It is an important resource for Oregon but is limited in its ability to meet Oregon's needs.

How it would work:

Eligibility: Similar to Oregon's current program but adding mental health professionals and dental hygienists. While the workforce shortages in rural communities are especially critical and require prioritization, there should be the potential for adding eligibility for certain high need urban areas based on poverty level, health disparities, and other indicators once the rural program is adequately and sustainably funded. This determination should be undertaken in consultation with the Office of Rural Health, Office of Health Policy and Research and Department of Human Services.

Program Parameters: Similar to current LRP. Potentially extend years and total eligibility amount. Target an actual number of loan repayers based on projected size of rural network we would like to sustain. Loan repayment can be pegged at 80% covered equally over four years and the remaining 20% as a bonus for an additional two years of service in a designated underserved area.

Penalties/Enforcing Provisions: Current LRP

Evaluation/Monitoring: Use Return on Investment (ROI) methodology to determine whole community benefit: calculate number of patients seen; determine retention rates (including how many remain in the same location and how many continue to serve underserved populations); obtain feedback from sites, communities and students. Provide data on outcomes to the Oregon Health Workforce Institute (OHWI). Secure OHWI participation in evaluation activities.

Administration: Office of Rural Health (stronger rural community connection) and/or Oregon Office of Health Systems Planning (HSP) where National Health Service Corps (NHSC) related expertise and coordination resides. The loan repayment administration should remain with the Oregon Student Assistance Commission (OSAC). Additional staffing of at least 1 FTE would be needed to assure the success of this program.

Additional Innovations and Linkages:

- Add robust communication and training component (technical assistance) over and above loan Repayment.
- A truly comprehensive program would include loan forgiveness as well as loan repayment. Loan forgiveness programs make the loans to students, and then

"forgives" repayment of those loans if the newly trained provider practices in identified areas of need. Loan repayment simply grants $ to be used to pay off student loans regardless of their source. Loan repayment is a short-term strategy; loan forgiveness is a longer-term strategy that enables us to cultivate rural Oregonian health professional students/providers.

- Integrate with clinical practice support resources (locum tenens, telehealth, protocols, rural health outreach, health professional training, Oregon Rural Practice-based Research Network, etc.).
- Link OHSC to Area Health Education Center (AHEC) pipeline activity at the high school level (link loan repayment information to pre-med students, pair students with loan recipients, create high school college- level memberships and other membership categories, etc.). This is in part a "branding" process to build a pipeline of future OHSC and to build sense of belonging to something important.
- Work out a mechanism to provide partial loan repayment to locum tenens providers who work in underserved areas of Oregon.
- Tie OHSCorps as a "community menu option" with strong technical assistance to support deployed practices and encourage provider retention.
- Add community generated incentives to OHSC membership; for example, in order to qualify for state support, a local community may have to provide an in-kind match that could consist of an equipped clinic/office facility, housing for the locum tenens and/or full-time provider and a community board of directors/advisors

Anticipated outcomes:

- Rural Oregon and the safety net is better able to compete with urban areas and other states
- Incentives are sufficient to draw needed professionals to rural areas and to the safety net

Cost and how it might be financed: Legislative appropriation

Assumptions:

Average physician/dentist/pharmacist educational debt = $130,000
Target 10 new physician/dentist loan repayment candidates per year =
Year 1 = 25% X 80% X 10 =$260,000
Year 2 = 25% X 80% X 20 =$520,000
Year 3 = 25% X 80% X 30 =$780,000
Year 4 = 25% X 80% X 40 =$1,040,000

Average other health professionals (nurse practitioners, physician assistants, radiographers, etc.) = $50,000
Target 20 new loan repayment candidates per year
Year 1 = 25% X 80% X 20 =$200,000
Year 2 = 25% X 80% X 40 =$400,000
Year 3 = 25% X 80% X 60 =$600,000
Year 4 = 25% X 80% X 80 =$800,000

Note: *Doesn't yet include costs for behavioral health, dental hygienists, or other providers or any additional staffing costs*

Projected Biennial Costs: with additional 1.0 FTE for the ORH and additional 1.0 FTE for OSAC
2009-2011 Biennium: $1,900,000 (includes some administrative costs)
2011-2013 Biennium: $ 3,900,000

Concept Summary:

Update Oregon's Tax Credit program

Increase tax credit amounts originally established in 1989 and include additional eligible provider categories to attract and retain the workforce that communities and the safety net depend on: physicians, mid-level practitioners, dentists and dental hygienists, and behavioral health practitioners including but not limited to psychiatrists, psychologists, social workers, and treatment specialists.

Issue it addresses:

This program was initiated in 1989. Eligible professions include physicians, podiatrists, nurse practitioners, physician assistants, and dentists, EMT's, optometrists and certified registered nurse anesthetists. Practitioners are eligible for up to $5K/year and most are able to claim the maximum amount. Approximately 1,750 received the benefit last year at an estimated biennial of $14.6 million. **Maximum per year of tax credit has not been modified** since the beginning of the program. A number of professionals important to rural Oregon and the safety net are not eligible.

How it would work:

The following modifications to the benefit are proposed:

- Increase the tax credit maximum from $5,000 to $10,000 per year.
- Broaden eligibility for **dentists** and add provisions to include **behavioral and mental health providers** to the program with proportional tax credits.
- The emergency medical technician (EMT) tax credit should be revised to include **first responders**. Eligibility requirements should be changed so that professional EMTs who also volunteer their services are not excluded. A bill was introduced in the 2007 legislature that did not pass and would have corrected that unintended exclusion.
- Add community paramedics and other community health workers identifying proportional tax credit maximums

Anticipated outcomes:

Rural areas of Oregon and the safety net will be more competitive with urban areas and other states in attracting necessary workforce.

Cost and how it might be financed: Legislature passes bill incorporating changes and appropriating dollars. Impact of changes to tax credit provisions needs to be determined.

Concept Summary:

Flexible Workforce Approaches for Rural Oregon

Build flexible responsive community health infrastructure by establishing multiple community or regional networks and targeting key outcomes. Expand the range of individuals able to provide emergency medical services, treat or assist with treatment of certain acute and chronic conditions, and provide preventive and health promotion services. Provide the necessary education, certification, and clinical oversight. Adopt necessary payer policies. The use of Para-professionals must be fiscally sustainable.

Requires partners co-creating an environment where sufficient individuals are licensed and/or trained and certified and able to do what needs to be done complemented by communities and regions that partner with each other to provide the necessary supporting infrastructure of supervision, coordination, administration, and financing. Local government and public health departments, hospitals, clinics, ambulance companies, local advocates make up the critical mass of energy, experience, and commitment. State government has a role to play as well. Many factors contribute to the success of such partnerships.

- This means focusing on what can be done without physicians, nurse practitioners or physicians assistants *directly* providing = emergency services, certain non-urgent acute care, certain preventive services, health education, care coordination and linking this capacity to necessary and affordable clinical oversight
- Training programs and certifications can enable EMTs to provide certain medical services, preventive services, and health education
- Public health and other nurses can perform this array of activities with additional certification as EMT and depending on the person, training in preventive care and health education and/or can provide some level of coordination of these resources
- Community Health Workers can provide care coordination, case management functions, and health promotion with appropriate training and certification as well as EMT functions in some communities
- Use Community Access Project "Pathways" model to manage toward specific individual health outcomes in support of clinical and public health strategies http://www.chap-ohio.net/documents/PathwaysManual.pdf
- Research on community health workers is not deep but some does exist and is suggested of positive outcomes in some areas
- Extensive recent HRSA workforce study provides much information to support design efforts - see http://bhpr.hrsa.gov/healthworkforce/chw/default.htm#preface
- Globally and national pilots and models have been implemented or are being designed and provide information to inform design efforts http://ircp.ncemsi.org/

- Public health, educational institution, managed care organization and others have shown interest in the development of such models
- State and local public health departments to work together to facilitate analysis regarding prevalence of conditions and risk factors can help target geographic areas and specific populations
- Depending on the communities or regions a clinical team could consist of physician, nurse practitioner, public health nurse, EMT/community paramedic, and community health worker.
- Specific certifications or combinations of training and licensing would depend on the needs identified, the resources available, and the level of community and regional commitment
- Deployment to specific communities would be based on identified community need
- The administrative "home" could be a public health department, hospital, FQHC, RHC, SBHC, or other mutually agreed upon entity capable of providing administrative support.

Issue it addresses:
Rural areas have limited resources to address a range of health related needs including responding to emergencies, providing routine care, managing chronic disease, and preventing illness and injury. At the same time hospitals and public health resources have been limited for similar economic reasons. Rural communities have responded to these kinds of needs through attempting to recruit and retain the traditional roles of physicians, mid-levels, first responders and emergency medical technicians, and in some cases, public health nurses and other staff, each with their own relatively limited scope of practice or program. The increasing cost of health care makes it ever more challenging to maintain a basic infrastructure for health and healthcare in rural and isolated areas of the state. A vital and healthy rural Oregon helps assure a higher quality of life for all Oregonians.

How it would work:
Provide initial grants for up to 4 multi-county and/or multi-community pilots:
- Maintain commitment for minimum of 4 years
- Applicants must include support or participation of local health departments, community collaboratives, AHEC, RHCs, critical access, A, B, hospitals, FQHCs, SBHC, volunteer clinics, EMS providers as relevant
- Community or other educational institutions participate and provide necessary training and certification
- Year 1 state provides 80% grant, year 2 - 60%, year 3 - 50% year 4 - 40% year 5 and on maximum state participation 30%
- Maximum ongoing state participation 50% if health district or other similar mechanism established and maintained or the area is isolated and rural
- Progress assessment at the end of each year, two year preliminary outcome assessment and four years evaluation
- If evaluation is positive existing commitments are maintained and new areas selected

- Options for administration include DHS, Local Public Health Departments, Office of Rural Health, Higher Education or a combination.
- Evaluation could utilize community based participatory research models
- Potential partnership with Oregon Rural Practice Based Research Network http://www.ohsu.edu/orprn/

Anticipated outcomes:

- Use of more expensive and difficult to recruit physicians are used to optimal benefit coordinating the delivery of care across rural areas of Oregon
- Local healthcare and public health resources are more effectively utilized to create desired health outcomes
- More options for local residents to earn a living and contribute to their communities are created
- The needs of Oregon's rural communities and the resources of higher education are more effectively aligned to mutual benefit

Cost and how it might be financed: Through legislative appropriation. Model cost would decline over time to minimum state subsidy level. If successful at achieving outcomes model could be expanded to other areas of the state. See above.

Ball Park Estimated Cost to Imply Order of Magnitude

- $2,000,000 year 1
- $1,500,000 year 2
- $1,000,000 year 3
- $1,000,000 year 4
- 4 year total = $5,000,000

Cost elements include:

- Staffing cost depending on mix
- Staffing cost depends on existing mix
- Curriculum and instruction
- Clinical supervision
- Locum tenens as needed
- Travel
- Higher education related
- Assessment and evaluation
- Administration
- Insurance
- Facility related

Delivery System Committee
Strawperson Policy Recommendations
Promotion of Integrated Health Homes
DRAFT FOR DISCUSSION ONLY 1/17/08

Oregon's primary health care delivery system must be radically transformed in an effort to improve individual and population health and wellness. This transformation should be guided by the concept of the integrated health home and must involve a revitalization of primary care, as well as other health and social services that are to vital components of a system equipped to meet the health needs of the population. The state should take bold steps to partner with consumers, providers, purchasers and payers around the common goal and vision of providing every Oregonian with an integrated health home.

Recommendation 1: Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Board Program, with eventual statewide adoption to ensure integrated health homes are available to all Oregonians.

Timeline: By ____ (2, 5, 10 years?), every member of the Oregon Health Fund Program should have access to an integrated health home. By ____ (2, 5 10 years?), there should be widespread statewide adoption of the integrated health home model that ensures every Oregonian has access to an integrated health home.

Definition: A standard definition of integrated health home should be developed for Oregon that allows for innovation and encompasses a range of models. The Delivery System Committee recommends the following definition, which is a modified definition of a patient-centered medical home, as developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA).
Key aspects to include are:

- *Personal connection with practice* **–** Every patient has available an established and continuous relationship with a provider or provider group working in a practice that meets all criteria of an integrated health home. This could be with a primary care physician, nurse practitioner or others trained to provide longitudinal health care services. These services can be provided within the care setting or through coordinated virtual networks.
- *Team-based Care* - A coherent team of providers working at the top of their licenses, who are collectively responsible for the patient's longitudinal health needs. Empowered patient and patient's family (when appropriate) play active and central role in team-based care. Roles within the team are assigned to maximize the efficient use of resources and responsiveness to patient needs.
- *Whole Person Orientation* **–** Integrated health homes assumes responsibility for providing culturally competent care for all of the patient's health care needs,

including preventive care, disease management services, acute care and end of life. The integrated health home provides direct care when possible and arranges for appropriate referrals to other providers and other health and social services.

- *Coordinated and Integrated Care* - Care received from the integrated health home is coordinated/integrated with care received from other providers and organizations, as well as with services provided within a patient's community, including public health, oral health, mental health, and behavioral health services. Coordination allows patients to receive appropriate care when and where they need it. Registries, information technology, information exchange, and other resources are utilized by the integrated health home to establish and facilitate coordination.
- *Quality and Safety* – Integrated health homes focus on quality improvement and safety, through physician participation in performance measurement and improvement efforts, use of clinical decision-support technology, and clinical standards and guidelines built on evidence-based medicine. Patients participate in shared decision-making, quality improvement efforts and practice evaluation.
- *Enhanced Access* – Patient access to both office-based and non-office based care is expanded through mechanisms such as longer hours, group visits, open scheduling, phone and email visits, and other web-based communication.

Recommendation 2: Create and support interactive systems of care (real and virtual) which connect integrated health homes with community-based services, public health, behavioral health, oral health, and social services to improve population health. These systems should have the ability to provide feedback on population health statistics, population based outcomes measures and improvement across the delivery system.
Staff will discuss possible strategies with other state agencies and develop options for Committee to consider.

Recommendation 3: Provide Oregon's health care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes. This support must be provided to Oregon's primary care workforce, as well as other health care and social service personnel needed to provide individual and population health, coordination and management services vital to the integrated health home model.
State strategies for responding to primary care workforce shortage will be addressed in future recommendations. Workforce recommendations will need to address shortage of primary care workforce, as well as other health care and social service personnel.

Options to consider:

- Forum for those participating/funding demonstration projects to come together to share best practices and discuss challenges
- Learning collaboratives that give providers and other stakeholders the opportunity to share and develop best practices and partner with public health to facilitate the use of data to improve individual and population health
- Funds for demonstration projects, especially in rural and underserved areas. May consider funding demonstration projects where specialist (e.g. endocrinologist for

patient with diabetes or mental health professional for patient with mental illness or dentist) serves as integrated health home
- Grants to practices to build HIT infrastructure, disease registries, etc.
- Ongoing financial support (possibly through payment reform) for pilot and demonstration projects that prove to be successful in improving quality of care and health outcomes
- System improvement training and other technical assistance

Recommendation 4: Develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.

Options to consider:
- Pilot and evaluate strategies to provide rewards/incentives for Oregon Health Fund Program participants who enroll with integrated health home, seek preventative services, effectively manage chronic disease with support from health homes, practice healthy behaviors, etc.
- Develop tools and provide training to help providers more effectively communicate with patients and to provide culturally appropriate care
- Educate public about benefits of enrolling with integrated health homes
- Explore opportunities to integrate shared decision making tools into care of Oregon Health Fund Program enrollees, as well as other Oregonians

Recommendation 5: Develop reimbursement and funding strategies that promote and sustain integrated health homes and other system of care partners that include.

1) *Acknowledge and support initial pilots underway across the state and use the lessons and best practices from these pilots to design, promote and/or fund larger scale demonstration projects. These demonstrations should aim to develop new integrated health home models, as well as new models of reimbursement that adequately compensate and support providers and other associated workforce for delivering integrated health home services.*

2) *Develop standard policies that tie reimbursement to requirements to report on common measures of integrated health home process and performance and system performance measures.*
   - The common set of measures should build on national standards and current efforts to measure quality, cost, and efficiency in Oregon. Measures should include process and outcomes measures, be designed to measure longitudinal clinical outcomes for individuals as well as provider panels, and include measures of population health. A process should be developed to ensure that measurement and designation process is fluid and regularly updated. Such measurement could be via the Quality Institute, which could also be responsible for collecting baseline data. *Await Quality Institute WG recommendations*
   - Common measures should allow for comparative analysis of integrated health homes to improve individual and population health, as well as patient and physician experience.

3) *Design a simple and standard process to designate primary care practices as integrated health home. The designation process should be based on measurements included in the common set of measures (see #2 above).*
   - Designation process must be simple and tiered to acknowledge various levels of progress toward evolution into fully integrated health homes.
   - Designation process should be built on common measures to minimize burden of reporting requirements on providers.
   - Payment for integrated health homes (see #4 below) should be based on tiered designation process.

4) *Develop long-term sustainable payment policies that appropriately compensate providers and other partners involved in integrated health home systems of care for developing capacity to provide integrated health home services and providing these services to Oregonians in a high-quality and high-value manner. New payment strategies should be tested and evaluated to determine the potential to improve patient outcomes and experience, as well as provider experience.*
   - A mixed model of reimbursement will probably have to be developed, which includes fee for service payments for certain procedures and risk-adjusted bundled payments for providing integrated health home services. Payment should be tied to reporting requirements of common measures (see #2 above) and an auditing process will have to be developed.

The Implications of Regional and Provider-specific Variations in Medicare Spending for Medicare Payment Reform

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Invited Testimony
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives

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The Implications of Regional and Provider-specific Variations in Medicare Spending for Medicare Payment Reform

Summary of Major Points

The Medicare Payment Advisory Commission Report *Assessing Alternatives to the Sustainable Growth Rates System* provides an outstanding analysis of the key issues and challenges confronting Congress as it considers how to reform current Medicare approaches to provider payment during a period of serious budget constraints.

Nearly two-fold differences in Medicare spending exist across U.S. regions and across the populations cared for by major academic medical centers. These cannot be explained on the basis of differences in patients' needs for care or to differences in prices. Rather they are due largely to differences in the volume -- or overall intensity of care -- and are largely explained by greater tuse of what we call "supply-sensitive services" -- discretionary services such as the frequency of physician visits, use of specialists as opposed to primary care physicians, the use of the acute care hospital as a site of care, and the frequency of diagnostic tests and imaging.

Higher spending regions, academic medical centers and hospitals do not provide better care. On the contrary, the evidence suggests that higher spending is associated with lower quality; and U.S. regions that grew fastest fell somewhat further behind in their quality and outcomes.

This research highlights the magnitude of the opportunity to improve the value of Medicare services and provides further support for several key payment reform principles that are embedded in the Commission's Pathway Two: ensuring that incentives to control spending growth apply to all providers, whether through expenditure targets or other means and striving to reduce regional disparities in spending by applying greater pressure on currently high-spending regions.

Our research also provides strong support for the importance of fostering the development of Accountable Care Organizations -- local integrated delivery systems that (1) are large enough to support comprehensive performance measurement, (2) can provide or effectively manage the full continuum of patient care; (3) could participate in shared-savings approaches to payment reform as an interim step toward fundamental payment reform.

Accountable Care Organizations should be a key element of payment reform for the following reasons: (1) Most physicians already practice within "virtual" multi-specialty group practices; modest incentives might prompt physicians to establish formal organizations that would neither disrupt their current practice patterns or their patients' care; (2) ACOs could be given incentives to control total Medicare payments, allowing budgetary savings with smaller relative impact on provider revenues; (3) Performance measurement at the level of an ACO would be much more tractable in the near term. (4) ACOs are more likely to have the capacity to invest in the infrastructure required to improve care, such as electronic health records and care management protocols.

We have shown that growth in spending on physician services varies dramatically across empirically defined "virtual" multi-specialty group practices, ranging from a low of 2.4% per year in the slowest growing fifth to almost 10% per year in the highest growing groups. We can therefore identify the ACOs who are most responsible for the growth in spending -- and those that offer a path toward improved value for Medicare.

Thank you Mr. Chairman, Congressman Deal, and distinguished members of the Committee for your invitation to address you today.

There is broad agreement on the scope of the challenges facing the U.S. health care system. The quality of care is remarkably uneven. Costs are rising at rates that threaten the affordability of care. And there is broad agreement that our current approach to paying for medical care is part of the problem.

The recently released Medicare Payment Advisory Commission report *Assessing Alternatives to the Sustainable Growth Rates System* provides an outstanding analysis of the key issues and challenges confronting Congress as it considers how to reform current Medicare approaches to provider payment during a period of serious budget constraints. The report also outlines a broad array of policy approaches that Congress and CMS could pursue to improve the quality and costs of care for Medicare beneficiaries. I find that I agree with almost all of their recommendations.

In particular I endorse their central recommendation: Congress should make a substantial investment in Medicare's capability to develop, implement, and refine payment systems that will reward higher quality care and efficient use of resources. I am also in general agreement with their analysis of the underlying causes of poor quality and rising costs and their general prescriptions: improved performance measures, reform of payment policies toward a system that rewards both improved quality and lower costs.

My research with colleagues at Dartmouth most relevant, however, to three key payment reform principles that are embedded in the Commission's Pathway Two: (1) Ensuring that incentives to control spending growth apply to all providers, whether through expenditure targets or other means; (2) Striving to reduce regional disparities in spending by applying greater pressure on currently high-spending regions; (3) Fostering the development of Accountable Care Organizations.

In the remainder of my testimony, I will briefly summarize the key findings of our research on variations in Medicare spending, what we have learned about the likely causes of these differences, and then discuss why a focus on fostering organizational accountability should be a key part of any payment reform strategy.

Variations in Medicare Spending

Over thirty years ago, John Wennberg published his seminal article documenting the remarkable variations in practice and spending across small areas of Vermont.[1] With core support from the Robert Wood Johnson Foundation, and more recently from the National Institutes of Aging, we applied these methods to the Medicare population and found variations of a similar magnitude (Figure 1).[2] Per-capita spending on Medicare beneficiaries residing in regions such as Miami, Los Angeles and Manhattan is more than 60% greater than for those residing in Minneapolis, Sacramento, or Rochester, NY. We have now repeated these studies focusing on the chronically ill populations served by hospitals and their medical staffs.[3, 4] Even among the top 15 "Honor Roll" academic

medical centers (based upon US News and World Reports rankings), we find two fold differences in per-beneficiary spending on severely ill patients. (Figure 2). Most of the variation in spending across these institutions is due to differences in the volume (or intensity) of services, not to differences in price.

Two critical questions are raised by these studies. What are the benefits, if any, of higher spending across US regions and hospitals? And, what are the causes of the differences we observe?

What are the benefits of higher spending?

Over the past ten years, we have completed a series of studies examining the implications of these differences in spending for the quality and outcomes of care received by Medicare beneficiaries (Figure 3). Overall, the technical quality of care, such as whether patients receive appropriate initial treatment for their heart attacks or timely preventive services, is somewhat worse in higher spending regions and hospitals.[2, 5] Those in higher spending regions don't receive more elective surgery.[2] Rather, the differences in spending are almost entirely due to differences in what we call "supply-sensitive services": the frequency of visits to physicians, how much time similar patients spending in the hospital, and differences in other discretionary services such as imaging, diagnostic tests and minor procedures.[2, 6]

Beneficiary satisfaction with care was no better in high spending regions and their perceptions of the accessibility of care were somewhat worse in high spending regions.[7] In terms of health outcomes, we found that mortality rates in higher spending regions and hospitals were either no better or slightly worse than in lower spending delivery systems.[7] Perhaps most worrisome was our finding that spending growth was greatest in higher spending regions (on average) and that in regions where spending growth was greatest, survival following heart attacks improved more slowly over recent years than in regions where spending growth was slowest.[8]

Studies comparing physicians' perceptions of their ability to provide high quality care present a similar picture. Physicians in higher spending regions are more likely to report that the continuity of their relationships with patients and their communication with other physicians is inadequate to support high quality care. On average, physicians in higher spending regions are more likely to report difficulty providing high quality care.[9]

These findings point to a troubling paradox: within the context of the U.S. health care delivery system higher spending is associated with lower quality of care and, on average, slightly worse outcomes.

What are the causes of higher spending?

Our more recent work has focused on trying to disentangle the underlying causes of the differences in spending and spending growth across regions. At this stage it is important to distinguish what we know, based on completed research, from what we think we know, our current best theory of what explains the findings.

The evidence

Patients' preferences for care vary slightly across regions, but not enough to explain the magnitude of spending differences we see. (For example, Medicare beneficiaries in high spending regions are no more likely to prefer aggressive end-of-life care than those in low spending regions[10, 11]). And differences in the malpractice environment explain only about 10% of state level differences in spending.[12] On the other hand, the local capacity of the health care delivery system varies dramatically across regions of differing spending levels. (Figure 4) High spending regions have 32% more hospital beds per-capita, 65% more medical specialists, and 75% more general internists (data not shown). [2] Moreover, it is well known that the current payment system tends to reward high margin services (such as invasive cardiovascular procedures) and ensures that any new capacity will remain fully utilized. (Lower two panels of Figure 4). Elyria, Ohio, for example, has for many years had the highest rates of angioplasty in the United States. A New York Times article described how the high financial rewards for performing this procedure led to the rapid growth of the cardiology group in Elyria.[13]

More recently, we have found that physicians' clinical judgment also varies across regions of differing spending levels.(Figure 5) In a study using clinical vignettes, primary care physicians in higher spending regions were much more likely to recommend discretionary treatments (such as more frequent visits or imaging) than those in low spending regions.[14] Where clinical evidence is stronger (as in referral to a cardiologist for chest pain and a markedly abnormal stress test), we found no association between physicians' decisions and local spending levels.

The theory: capacity, payment and clinical judgment in the "gray" areas

These findings suggest a likely explanation for the dramatic differences in spending across regions and the paradoxical finding that higher spending seems to lead to worse quality and worse outcomes (Figure 6). Current clinical evidence and principles of professionalism are an important, but limited, influence on clinical decision-making. Most physicians practice within a local organizational context and policy environment that profoundly influences their decision-making, especially in discretionary settings. Hospitals and physicians each face incentives that will in general reward expansion of capacity (especially for highly reimbursed services) and recruitment of additional procedure-oriented specialists. When there are more physicians, relative to the size of the population they serve, physicians will see their patients more frequently. When there are more specialists or hospital beds available, primary care physicians and other specialists will learn to rely upon those specialists and use those beds. (It is more efficient from the primary care physician's perspective to refer a difficult problem to a specialist or admit them to the hospital than to try to manage them themselves in the context of an office visit for which payments have become relatively constrained).

The consequence is that what appear to be reasonable individual clinical and policy decisions (given the current payment system) lead in aggregate to higher utilization rates, greater costs and, inadvertently, worse quality and worse outcomes. The key element of this theory is that because so many clinical decisions are in the "gray areas" (how often to

see a patient, when to refer to a specialist, when to admit to the hospital), any expansion of capacity will result in a subtle shift in clinical judgment toward greater intensity.

Harm could occur through several mechanisms.[15] Greater use of diagnostic tests could find more abnormalities that would never have caused the patient any problem (a condition referred to as "pseudodisease"). Because most treatments have some risks, providing those treatments to patients who don't need them could cause harm. And as care becomes more complex and more physicians are involved, it will be less and less clear who is responsible for each aspect of a patients' care. Miscommunication -- and errors -- become more likely.

Implications: accountable care, performance measurement and payment reform

Although there are a broad array of policy levers that could be brought to bear (see Figure 7 and the excellent discussion in Chapter 3 of the Commission's report), this causal model suggests that reform efforts should include a focus on fostering local organizational accountability for quality and total-per beneficiary costs (through comprehensive performance measurement) and eventual payment reform. The model also suggests that a critical element of any successful strategy will be to control the future growth of capacity -- whether within a local integrated delivery system or at the state or national levels. [1]

There are a number of current organizations that could serve as "Accountable Care Organizations" (Figure 8) -- local delivery systems that are large enough to support comprehensive performance measurement, can provide or effectively manage the continuum of care as a real or virtually integrated delivery system, and are capable of prospective budgeting and planning their resource and workforce needs. These include large multi-specialty group practices that own their own hospitals, physician-hospital organizations or other large integrated physician practice networks, hospitals that own their own physician groups, and, perhaps, the Extended Hospital Medical Staff (EHMS).[17]

The EHMS is an empirically defined (i.e. "virtual") multi-specialty group practice directly or indirectly affiliated with a single hospital. Our analyses of Medicare claims data found the following.[17]

- Almost all physicians can be empirically assigned to a single hospital, based upon where they provide inpatient care or where their patients are admitted.
- Medicare beneficiaries cared for by these physicians tend to receive most of their care from within the group, from their affiliated hospital, or from a single other hospital and its physicians (often an obvious referral hospital).

[1] The evidence reviewed above is also relevant to debates about the physician workforce. If low-spending regions can achieve equal or better outcomes and quality than high spending regions, we may be able to meet future workforce needs without growing the workforce further.16. Goodman DC. The physician workforce crisis: where is the evidence? Health Aff (Millwood) 2005;Suppl Web Exclusives:W5-108-W5-10.

Although there are a number of barriers to the universal implementation of ACOs through either the EHMS or other models[18], the advantages of a payment reform strategy that included fostering ACOs include at least the following (Figure 9).

(1) Most physicians already practice within relatively coherent real or virtual ACOs. Because most physicians already practice within informal practice networks that are more or less tightly affiliated with one or more hospitals (as discussed above), modest incentives and removal of current legal barriers could encourage them to establish formal relationships for the purpose of performance measurement, pay-for-performance rewards, shared savings or other gainsharing arrangements that would require little disruption of their current referral patterns.

(2) Effective performance measurement would be more tractable. Current performance measurement efforts focused on individual physicians confront numerous difficulties, including the narrow scope of quality measures available, potential limitations of episode groupers as measures of costs, the difficulty of attributing care to a single physician, the lack of performance measures for many specialties, and the relatively small number of patients that may be specifically attributable to any single physician. An even more important concern is the broader scope of measures that become possible at the level of an ACO. The Institute of Medicine's recent reports on performance measurement and pay-for-performance both call for the development of measures that focus on the longitudinal experience of Medicare beneficiaries (including measures of total costs and health outcomes), as well as measures that directly address the current fragmentation of patient care. Measuring at the ACO level increases the number of physicians whose care can be assessed (at some level) and the number of patients who contribute to measures (Figure 9) as well as the breadth of measures that are feasible. Figure 10 provides several examples based upon existing Medicare claims-based measures. But with appropriate risk adjustment, measures of health outcomes (such as surgical mortality rates or outcomes following acute myocardial infarction) would also be possible. [19] Finally, there are important practical advantages: the administrative complexity of data collection methods and auditing procedures for 5000 hospitals would be much less daunting than those required to collect and audit data on the more than 500,000 individual physicians practicing in the United States.

(3) Measures and incentives could encompass total Medicare program payments. A focus on Accountable Care Organizations could (as Figure 11 demonstrates) include a broader array of spending measures beyond physician services. This particular example includes utilization by Medicare beneficiaries cared for within EHMS-defined ACOs. Measures include not only spending on physician services, but also hospital spending and SNF utilization. Work is currently underway by the Dartmouth Atlas project to add the remaining categories (long-stay hospitals, outpatient services, home health and hospice) so that these may be presented at the ACO (hospital or EHMS) levels. An advantage of focusing expenditure targets on total program payments is that the real problem confronting Congress is Medicare spending growth (not just physician spending) and that including all Medicare providers under a revised expenditure target would allow Congress to achieve a given budgetary savings with lower relative reductions in any specific providers' incomes.

(4) ACOs would have the capacity to invest in system improvement and are the right level for efforts to control costs. Evidence is growing that health plans and hospitals have responded to current public reporting and pay-for-performance initiatives. Large-multispecialty medical groups have also been found to be more likely to invest in electronic health records and care management systems.

The most important reason, however, to focus on ACOs is to establish accountability for local decisions about capacity and thus costs. As was discussed above, local decisions that influence capacity -- capital investments, recruitment, and individual physicians' choices about practice location -- are likely to be the first step in the causal chain leading physicians to adopt more intensive practice patterns, and to the overuse of supply-sensitive services. Figure 12 shows how ACOs defined using the Extended Hospital Medical Staff method differed in terms of growth in per-beneficiary spending between 1999 and 2003. The lowest spending two fifths of these ACOs grew at less than 5% per year, while the highest growth groups had annual increases in per-beneficiary spending on physician services of almost 10 percent. Although further analyses are under way to explore the causes of these differences, it is likely that the more rapid increases are a function not only of increased volume per physician, but also of increases in the numbers of physicians providing services or the addition of new diagnostic, imaging or inpatient services. Comprehensive measures of longitudinal quality and costs at the ACO level would bring the impact of such decisions to light.

Challenges facing the development of ACOs

While the potential advantages of fostering the development of ACOs are substantial, serious barriers to moving in this direction must be acknowledged.

The current market. Under a payment system that now largely focuses on controlling the prices of individual services, but continues to disproportionately reward high technology procedures and those providers who own their facilities or increase their volume of services, physician entrepreneurial activity has increased dramatically. The consequence has been an increase in direct competition between physicians and hospitals. Reversing these trends may be difficult.

Cultural barriers. Physician practice and professional identity in the United States has long been characterized by a high degree of professional autonomy and a culture of individual responsibility -- both of which are reinforced by current medical training, professional malpractice liability programs and payment systems. Although there are numerous examples of physicians deeply engaged in collaborating with hospital administrators and nurses to improve the delivery of care, these remain relatively isolated examples. The notion of accepting a degree of responsibility for the care of all of the patients within their local delivery system will be resisted by many physicians.

Legal obstacles. Legal obstacles to physician-hospital collaboration are substantial, especially with regard to sharing the potential financial gains of more efficient care.[i]

Variability in the degree of alignment. Our data reveal substantial variability across hospitals in the degree to which physicians and patients are already aligned with a single hospital and a relatively coherent medical staff.

Moving forward

It is exactly these practical barriers, however, that make pursuing the notion of the Accountable Care Organizations worthy of further discussion and cautious efforts to test the ideas more fully. The alternative -- a narrow focus on provider performance assessment and pay-for-performance incentives aimed at individual physicians and institutional providers -- will require overcoming many of the same political and practical challenges. But it would also risk reinforcing the fragmentation and lack of coordination that characterizes the current delivery system. And any effort that fails to foster accountability for future capacity growth will be unlikely to rein in the growth of Medicare spending.

The remarkable differences in spending growth observed across existing empirically defined multi-specialty groups reveals that some are already growing at a rate that would not imperil the future health of the Medicare Trust Funds. Payment reform should include efforts to provide support and incentives that would allow all Medicare beneficiaries to receive care from local integrated delivery systems that achieve both high quality and a truly sustainable rate of growth.

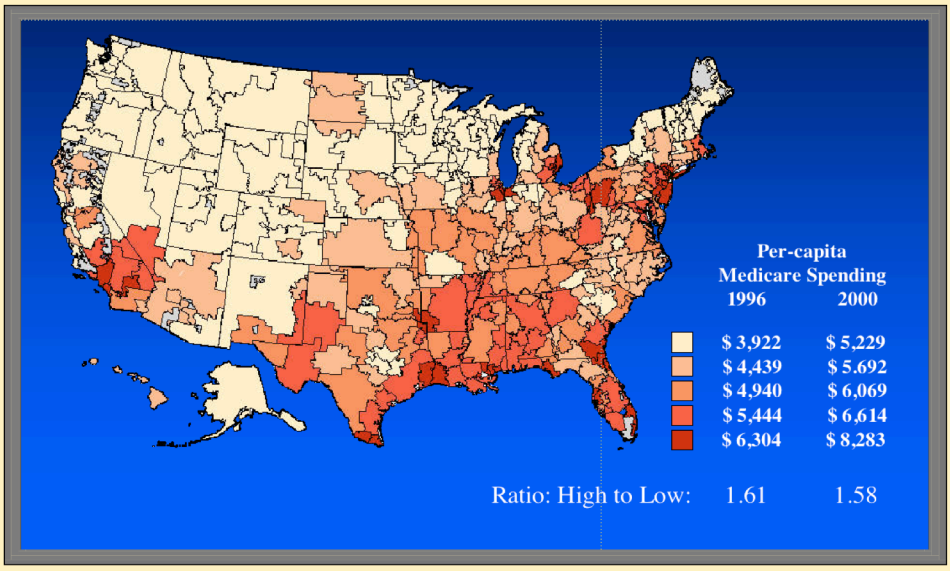
References

1. Wennberg J, Gittelsohn. Small area variations in health care delivery. Science 1973;182(117):1102-8.
2. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. Ann Intern Med 2003;138(4):273-87.
3. Wennberg JE, Fisher ES, Baker L, Sharp SM, Bronner KK. Evaluating The Efficiency Of California Providers In Caring For Patients With Chronic Illnesses. Health Aff (Millwood) 2005.
4. Wennberg JE, Fisher ES, McAndrew M. The Care of Patients with Severe Chronic Illness: A report on the Medicare program by the Dartmouth Atlas Project. Hanover, NH: Dartmouth College; 2006.
5. Baicker K, Chandra A. Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care. Health Aff (Millwood) 2004.
6. Wennberg JE, Fisher ES, Skinner JS. Geography and the debate over Medicare reform. Health Aff (Millwood) 2002;Supp Web Exclusives:W96-114.
7. Fisher ES, Wennberg DE, Stukel TA, Gottlieb DJ, Lucas FL, Pinder EL. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. Ann Intern Med 2003;138(4):288-98.

8. Skinner JS, Staiger DO, Fisher ES. Is technological change in medicine always worth it? The case of acute myocardial infarction. Health Aff (Millwood) 2006;25(2):w34-47.
9. Sirovich BE, Gottlieb DJ, Welch HG, Fisher ES. Regional variations in health care intensity and physician perceptions of quality of care. Ann Intern Med 2006;144(9):641-9.
10. Barnato AE, Herndon MB, Anthony DL, et al. Patient preferences do not explain regional variations in end-of-life treatment intensity. Under review.
11. Pritchard RS, Fisher ES, Teno JM, et al. Influence of patient preferences and local health system characteristics on the place of death. SUPPORT Investigators. Study to Understand Prognoses and Preferences for Risks and Outcomes of Treatment. J Am Geriatr Soc 1998;46(10):1242-50.
12. Kessler DP, McClellan M. Do Doctors Practice Defensive Medicine? Quarterly Journal of Economics 1996;111:353-90.
13. Abelson R. Heart Procedure is Off the Charts in an Ohio City. New York Times 2006 August 18, 2006;Sect. 1.
14. Sirovich BE, Gottlieb DJ, Welch HG, Fisher ES. Variation in the tendency of primary care physicians to intervene. Arch Intern Med 2005;165(19):2252-6.
15. Fisher ES, Welch HG. Avoiding the unintended consequences of growth in medical care: how might more be worse? Jama 1999;281(5):446-53.
16. Goodman DC. The physician workforce crisis: where is the evidence? Health Aff (Millwood) 2005;Suppl Web Exclusives:W5-108-W5-10.
17. Fisher ES, Staiger DO, Bynum JP, Gottlieb DJ. Creating accountable care organizations: the extended hospital medical staff. Health Aff (Millwood) 2007;26(1):w44-57.
18. Berenson RA, Ginsburg PB, May JH. Hospital-Physician Relations: Cooperation, Competiion or Separation. Health Aff 2006.
19. Krumholz HM, Normand SL, Spertus JA, Shahian DM, Bradley EH. Measuring performance for treating heart attacks and heart failure: the case for outcomes measurement. Health Aff (Millwood) 2007;26(1):75-85.

Figure 1. Variations in spending across regions

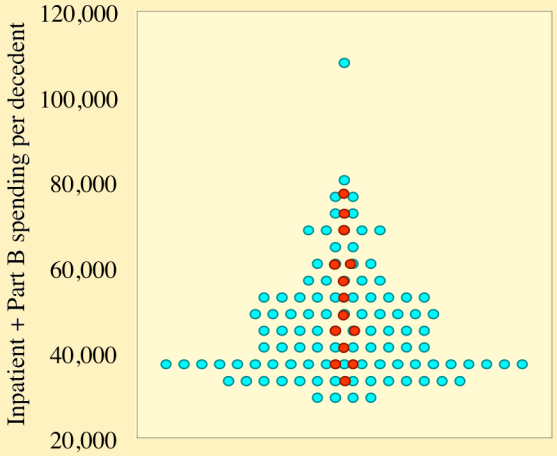
Variations in per-capita spending across U.S. regions. Each color grouping includes approximately one fifth of the Medicare population.



Fisher et al. Ann Intern Med: 2003; 138: 273-298

Figure 2. Variations in spending across medical centers

Variations in spending for patients with severe chronic disease across U.S. News and World Reports top 15 "Honor Roll" academic Medical Centers.



Spending per Medicare beneficiary with severe chronic disease
(Last 2 years of life, 2000-2003)

UCLA Medical Center	72,793
New York-Presbyterian	69,962
Univ. of Pennsylvania	61,290
Johns Hopkins	60,653
UCSF Medical Center	56,859
Brigham and Womens	53,123
Univ. of Washington	50,716
Univ. of Michigan	49,367
Mass. General	47,880
Barnes-Jewish	44,463
Duke University Hosp.	37,765
Mayo Clinic (St. Mary's)	37,271
Cleveland Clinic	35,455

Most of the differences in spending are due to differences in volume (or intensity), not price. For example, 66% of the variation in spending across academic medical centers can be explained by the number of inpatient days and physician visits alone.

Dartmouth Atlas of Health Care: www.dartmouthatlas.org

Figure 3. What does higher spending "buy"?

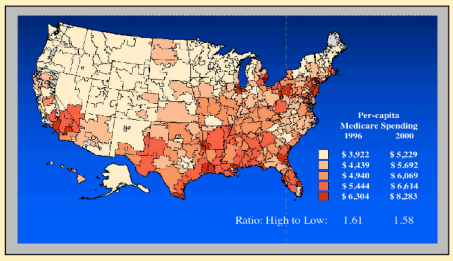
Compared to the lowest spending regions, what do residents of higher spending regions get for the additional $3000 per beneficiary (in 2000)?

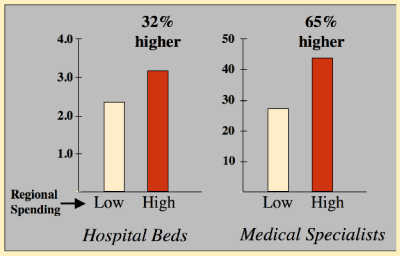
Resource levels[1]	*More hospital beds per capita (32%)* *More medical specialists (65%) and internists (75%)*
Content / Quality of Care[1,2]	*Technical quality worse* *No more major elective surgery*
Supply-sensitive services →	***More hospital stays, visits, specialist use, tests, procedures***
Health Outcomes[1,2]	*Slightly higher mortality* *No better function*
Physician-reported quality[5]	*Worse communication among physicians* *Greater difficulty ensuring continuity of care* *Greater difficulty providing high quality care*
Patient-reported quality[1,3]	*Lower satisfaction with hospital care* *Worse access to primary care*
Trends over time[4]	*Lower gains in survival (following AMI)*
Supply-sensitive services →	*Greater growth in per-capita resource use*

(1) Ann Intern Med: 2003; 138: 273-298
(2) Health Affairs web exclusives, October 7, 2004
(3) Health Affairs, web exclusives, Nov 16, 2005
(4) Health Affairs web exclusives, Feb 7, 2006
(5) Ann Intern Med: 2006; 144: 641-649

Figure 4. The role of supply and current payment systems

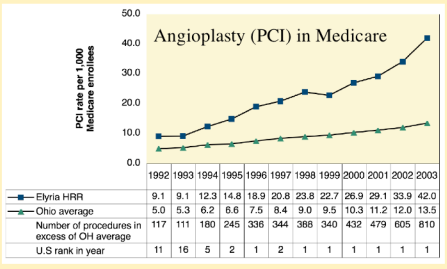
Compared to the lowest spending regions (tan) the highest spending regions have 32% more beds and 65% more specialists per-capita





Ann Intern Med: 2003; 138: 273-298

Current payment systems reward high margin services (e.g. angioplasty) and ensure that physicians stay busy: more cardiologists per capita --> more visits



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Elyria HRR	9.1	9.1	12.3	14.8	18.9	20.8	23.8	22.7	26.9	29.1	33.9	42.0
Ohio average	5.0	5.3	6.2	6.6	7.5	8.4	9.0	9.5	10.3	11.2	12.0	13.5
Number of procedures in excess of OH average	117	111	180	245	336	344	388	340	432	479	605	810
U.S rank in year	11	16	5	2	1	2	1	1	1	1	1	1

Dartmouth Atlas of Health Care: www.dartmouthatlas.org

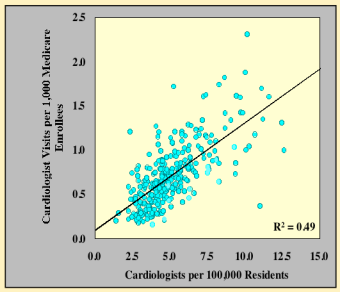


Figure 5. The role of judgment in discretionary settings

For clinical services where judgment is required and no clear guidelines existt physicians in high spending regions are more likely to intervene.

Percent of patients for whom physicians would recommend the intervention in low and high spending regions in each scenario:	**Low Spending Regions**	**High Spending Regions**	**Trend significant**
Cardiology referral for chest pain and abnormal stress test	91	93	no
Drug treatment of high cholesterol with no other risk factors	44	53	yes
Urology referral for mild symptoms of prostatic enlargement	23	32	yes
MRI for back pain and mildly abnormal nerve function	69	82	yes
Prostate cancer screening test for 60 year old white male	68	78	yes
Visit for patient with isolated high blood pressure in 3 months or less	22	49	yes

Sirovich *Archives of Internal Medicine.* 165(19):2252-6, 2005 Oct 24
Sirovich, *Journal of General Internal Medicine;*

Figure 6. Why is spending higher? Why might harm occur?

Clinical evidence (e.g. RCTs, guidelines) and principles of professionalism are a critically important -- but limited -- influence on clinical decision-making.

Physicians practice within a local organizational context and policy environment that profoundly influences their decision-making. Payment system ensures that existing (and new capacity) is fully utilized.

Consequence: *reasonable* individual clinical and local decisions lead, in aggregate, to higher utilization rates, greater costs -- *and inadvertently* -- worse outcomes

The more complicated care becomes, the more likely mistakes are to occur.

Hospitals are dangerous places if you don't need to be there.

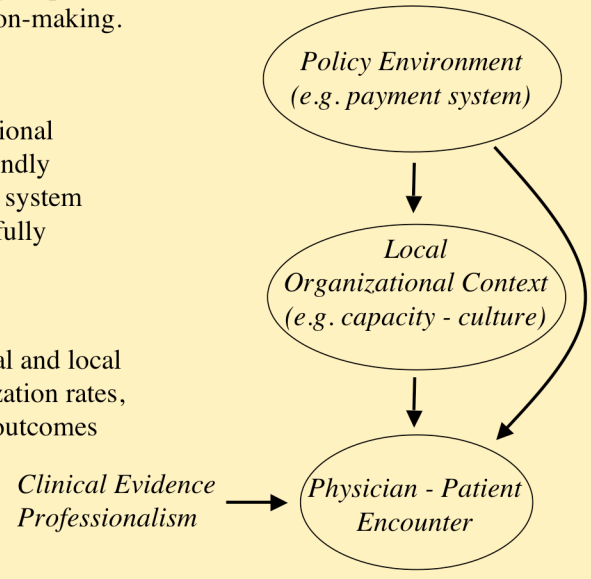


Figure 7. Potential policy levers

Research priorities (biology vs clinical practice)
Coverage policy
Performance measurement / Public reporting
Payment system reform
Workforce policy (medical schools, GME)

Recruitment / practice location decisions
Capital investment (hospital, outpatient)
Organizational structure (hospital, MD group)
Process management (QI, IT adoption)

Specialty certification
Graduate Medical Education
Continuing Medical Education
HIT for care and decision-support
Patient / public education and incentives

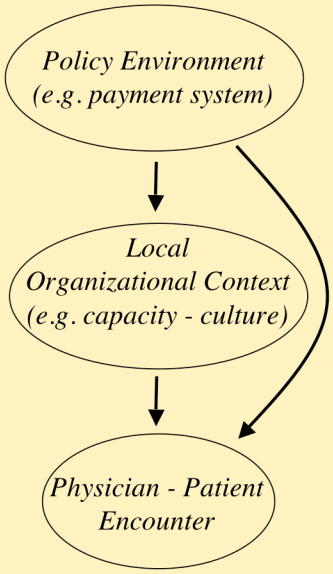


Figure 8. Fostering organizational accountability

Essential attributes of an Accountable Care Organization

- Sufficient size to support comprehensive performance measurement
- Provides (or can effectively manage) continuum of care as a real or virtually integrated local delivery system
- Capable of prospectively planning budgets, capacity and resource needs

Potential Accountable Care Organizations

- Large multi-specialty group practices that own their own hospitals
  (Mayo, Virginia Mason, Scott White, Cleveland Clinic, Partners)
- Physician-Hospital Organizations / Practice Networks
  (Middlesex Health System)
- Hospitals that own physician groups
  (Intermountain Healthcare, many rural hospitals)
- Extended Hospital Medical Staff

Figure 9. Why focus on developing ACO's?

Most physicians already practice within "virtual" ACOs

- Virtually all MDs (95%) and Medicare beneficiaries (93%) can be assigned based on claims data to their local hospital and its medical staff
- Most care is already delivered within these virtual multi-specialty groups
- Modest incentives might prompt physicians to establish formal organizations that would not have to disrupt their current practices or patient care.

Performance measurement is more tractable in the near term

- All physicians could be included in measurement with adequate sample sizes, less difficulty in attribution (see Figure 9).
- Diverse and important measures are feasible (see Figure 10).

Spending measures can include total Medicare payments

- Either SGR or shared savings models to have broader impact
- Could achieve comparable budgetary savings with smaller *relative* effect on providers' revenues

ACOs more likely to have capacity to invest in improvement: electronic health records, care management, etc

Fisher et al. *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*
Health Affairs; Published online, 12/05/06

Figure 10. Attributing care to individual physicians

If one assigns Medicare beneficiaries to the physician they see most often, many physicians will have no patients assigned. Sample sizes are too small to use for many important measures.

	Assessed as Individual Physicians		*Assessed as members of hospital extended staff*
	Among MDs with 1+ patient assigned (n = 254,250)	*Among all MDs (n = 572,637)*	*Among all MDs (n = 572,637)*
No patients	0	56	0
1 to 24	36	16	0.3
25-99	30	13	0.7
100-499	32	15	1.3
500 and over	1	1	97.7
	100%	100%	100%

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Health Affairs; Published online, 12/05/06

Figure 11. Diverse performance measures possible

Among ACOs defined by extended hospital medical staff method and stratified by physician spending levels in 2003, average performance varies little in technical quality, but substantially in terms of utilization rates, care transitions, and spending (in standardized prices)*

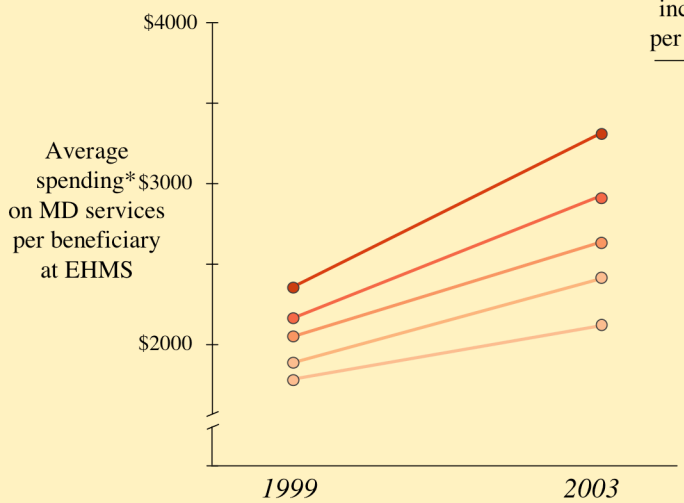
	Low Spending	*Middle*	*High Spending*	***Ratio High to Low***
Mammography 65-69	47.8	48.6	47.2	**0.99**
Eye exams, diabetes	39.0	40.5	41.5	**1.06**
HBA1c, diabetes	54.9	56.5	54.5	**0.99**
Hospital Discharges§	330	367	390	**1.18**
SNF stays §	74.3	75.7	81.7	**1.10**
Care transitions	0.86	0.92	0.97	**1.13**
*Physician services***	$2,085	$2,560	$3,295	**1.58**
Acute care hospital	$2,086	$2,432	$2,649	**1.27**

* Defined using 2003 standardized payments based upon RVUs
** Physician and hospital spending calculated using standardized national prices (spending and utilization data are age-sex-race adjusted)
§ per 1000 beneficiaries

Fisher et al. *Creating Accountable Care Organizations: The Extended Hospital Medical Staff* Health Affairs; Published online, 12/05/06

Figure 12. Relative growth in spending varies

Growth in per-beneficiary spending on physician services across ACOs defined by Extended Hospital Medical Staff method (n = 4772) stratified into quintiles by magnitude of per-beneficiary growth (1999-2003)



Absolute increase per benef.	Percent increase 99-03**	Average Annual Rate
$936	46%	9.9%
$675	33%	7.3%
$551	27%	6.1%
$431	21%	4.8%
$198	10%	2.4%

* Using standardized payments, using 2003 RVU
** Percent increase calculated relative to *average* U.S. 1999 per-beneficiary spending in order to assess relative contribution to aggregate growth.

Source: Fisher and Gottlieb, MedPAC analyses, December 2006

hrrname	hsaname	Hospital	ndocs assigned hosp	pct_worksite	nbenes (20%)	loyalty e&m	loyalty prim & sec em
OR- EUGENE	OR- ALBANY	SAMARITAN ALBANY GENERAL HOSPITAL	47	0.80	376	0.70	0.72
OR- MEDFORD	OR- ASHLAND	ASHLAND COMMUNITY HOSPITAL	35	0.84	394	0.57	0.62
OR- PORTLAND	OR- ASTORIA	Columbia Memorial Ho	24	0.52	482	0.73	0.75
ID- BOISE	OR- BAKER	ST ELIZABETH HEALTH SERVICES, INC	13	0.81	391	0.80	0.83
OR- BEND	OR- BEND	CHS,INC DBA ST CHARLES MEDICAL CTR-BEND	146	0.63	2093	0.84	0.86
OR- EUGENE	OR- COOS BAY	SOUTHERN COOS HOSPITAL AND HEALTH CTR	<11	1.00	125	0.58	0.61
OR- EUGENE	OR- COOS BAY	COQUILLE VALLEY HOSPITAL	<11	1.00	223	0.58	0.58
OR- EUGENE	OR- COOS BAY	LOWER UMPQUA HOSPITAL	12	0.88	246	0.66	0.82
OR- EUGENE	OR- COOS BAY	BAY AREA HOSPITAL	65	0.70	1446	0.87	0.88
OR- EUGENE	OR- CORVALLIS	GOOD SAMARITAN REGIONAL MEDICAL CTR	96	0.64	1093	0.83	0.85
OR- EUGENE	OR- COTTAGE GROVE	COTTAGE GROVE COMMUNITY HOSPITAL	<11	0.92	239	0.59	0.62
OR- SALEM	OR- DALLAS	VALLEY COMMUNITY HOSPITAL	<11	1.00	158	0.60	0.62
WA- SPOKANE	OR- ENTERPRISE	WALLOWA MEMORIAL HOSPITAL	<11	0.82	219	0.72	0.72
OR- EUGENE	OR- EUGENE	SACRED HEART MEDICAL CENTER	255	0.55	2877	0.86	0.86
OR- EUGENE	OR- FLORENCE	PEACE HARBOR HOSPITAL	19	0.72	369	0.49	0.49
OR- MEDFORD	OR- GOLD BEACH	CURRY GENERAL HOSPITAL	<11	0.71	155	0.61	0.64
OR- MEDFORD	OR- GRANTS PASS	ASANTE THREE RIVERS COMM HOSPITAL LLC	87	0.68	1743	0.77	0.79
OR- PORTLAND	OR- HERMISTON	GOOD SHEPHERD MEDICAL CENTER	26	0.71	460	0.71	0.72
OR- PORTLAND	OR- HILLSBORO	TUALITY HEALTHCARE	82	0.58	773	0.79	0.79
OR- BEND	OR- JOHN DAY	BLUE MOUNTAIN HOSPITAL	<11	1.00	126	0.71	0.74
OR- MEDFORD	OR- KLAMATH FALLS	MERLE WEST MEDICAL CENTER	75	0.68	1486	0.88	0.88
OR- MEDFORD	OR- LAKEVIEW	LAKE DISTRICT HOSPITAL	<11	0.83	165	0.74	0.85
OR- EUGENE	OR- LEBANON	Samaritan Lebanon Co	35	0.76	463	0.78	0.78
OR- PORTLAND	OR- LINCOLN CITY	NORTH LINCOLN HOSPITAL	13	0.75	422	0.63	0.65
OR- BEND	OR- MADRAS	Mountain View Hosp D	12	0.78	109	0.59	0.60
OR- PORTLAND	OR- MCMINNVILLE	WILLAMETTE VALLEY MEDICAL CTR	49	0.67	640	0.78	0.79
OR- MEDFORD	OR- MEDFORD	PROVIDENCE MEDFORD MEDICAL CENTER	62	0.79	1285	0.54	0.57
OR- MEDFORD	OR- MEDFORD	ROGUE VALLEY MEDICAL CENTER	135	0.60	1820	0.75	0.78
OR- PORTLAND	OR- NEWBERG	PROVIDENCE NEWBERG HOSPITAL	24	0.81	165	0.65	0.66
OR- PORTLAND	OR- NEWPORT	SAMARITAN PACIFIC COMMUNITIES HOSPITAL	18	0.76	469	0.66	0.66
ID- BOISE	OR- ONTARIO	HOLY ROSARY MEDICAL CENTER	38	0.66	933	0.77	0.82
OR- PORTLAND	OR- OREGON CITY	WILLAMETTE FALLS HOSPITAL	50	0.57	549	0.67	0.70
OR- PORTLAND	OR- PORTLAND	LEGACY EMANUEL HOSPITAL & HEALTH CTR	49	0.50	405	0.51	0.61
OR- PORTLAND	OR- PORTLAND	PROVIDENCE MILWAUKIE HOSPITAL	54	0.71	447	0.64	0.68
OR- PORTLAND	OR- PORTLAND	LEGACY MOUNT HOOD MEDICAL CENTER	42	0.60	482	0.63	0.68
OR- PORTLAND	OR- PORTLAND	OHSU HOSPITAL AND CLINICS AND DOERNBEC	158	0.49	744	0.57	0.61
OR- PORTLAND	OR- PORTLAND	ADVENTIST MEDICAL CENTER	88	0.49	828	0.67	0.70
OR- PORTLAND	OR- PORTLAND	LEGACY GOOD SAMARITAN HOSP & MED CTR	128	0.51	1012	0.61	0.64
OR- PORTLAND	OR- PORTLAND	PROVIDENCE PORTLAND MEDICAL CENTER	243	0.59	1994	0.73	0.74
OR- PORTLAND	OR- PORTLAND	PROVIDENCE ST VINCENT MEDICAL CENTER	261	0.52	2204	0.70	0.74
OR- BEND	OR- PRINEVILLE	PIONEER MEMORIAL HOSPITAL	<11	0.78	185	0.61	0.61
OR- BEND	OR- REDMOND	CENTRAL OREGON DISTRICT HOSPITAL	23	0.92	417	0.67	0.68
OR- EUGENE	OR- ROSEBURG	MERCY MEDICAL CENTER INC	102	0.68	2142	0.84	0.86
OR- SALEM	OR- SALEM	SANTIAM MEMORIAL HOSPITAL	<11	0.68	155	0.65	0.67
OR- SALEM	OR- SALEM	SALEM HOSPITAL	213	0.52	2407	0.87	0.88
OR- PORTLAND	OR- SEASIDE	PROVIDENCE SEASIDE HOSPITAL	16	0.67	275	0.61	0.71
OR- PORTLAND	OR- SILVERTON	SILVERTON HOSPITAL	33	0.88	347	0.74	0.75
OR- EUGENE	OR- SPRINGFIELD	MCKENZIE-WILLAMETTE MEDICAL CENTER	44	0.74	618	0.66	0.67
OR- PORTLAND	OR- THE DALLES	MID-COLUMBIA MEDICAL CENTER	31	0.65	628	0.83	0.86
OR- PORTLAND	OR- TUALATIN	LEGACY MERIDIAN PARK HOSPITAL	100	0.58	1330	0.69	0.73

Ndocs assigned	number of physicians providing care to Medicare beneficiaries assigned to this hospital
pct_worksite	Percent of those physicians wilth inpatient billing
n benes(20%)	Number of Medicare beneficiaires assigned to the hospital
Loyalty e&m	Proportion of all evaluation and management services for assigned benes that are provided by physicians assisgned to the hospital
Loyalty Prim & sec	Proportion of e&m services provided by physicians assigned to primary (listed) hospital and next most frequently used hospital

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 1. Hospital information	
			Number of deaths among chronically ill patients assigned to hospital, 1999-2003	Percent of enrollees' medical inpatient days at hospital to which they were assigned*
Samaritan Albany General Hospital	Albany	OR	540	94.1
Ashland Community Hospital	Ashland	OR	313	92.4
Columbia Memorial Hospital	Astoria	OR	449	91.1
St. Elizabeth Health Services Inc.	Baker City	OR	425	93.9
St. Charles Medical Center	Bend	OR	1,405	94.1
Harney District Hospital	Burns	OR	126	90.6
Bay Area Hospital	Coos Bay	OR	1,585	94.4
Coquille Valley Hospital	Coquille	OR	167	89.3
Lower Umpqua Hospital	Reedsport	OR	168	94.3
Southern Coos General Hospital	Bandon	OR	193	85.7
Good Samaritan Regional Medical Center	Corvallis	OR	750	93.7
Valley Community Hospital	Dallas	OR	140	91.5
Wallowa Memorial Hospital	Enterprise	OR	188	94.0
Sacred Heart Medical Center	Eugene	OR	2,313	94.3
Peace Harbor Hospital	Florence	OR	286	93.2
Curry General Hospital	Gold Beach	OR	208	82.3
Three Rivers Community Hospital & Health	Grants Pass	OR	1,512	95.4
Good Shepherd Medical Center	Hermiston	OR	477	91.8
Tuality Healthcare	Hillsboro	OR	756	92.4
Providence Hood River Memorial Hospital	Hood River	OR	302	92.8
Blue Mountain Hospital District	John Day	OR	146	93.3
Merle West Medical Center	Klamath Falls	OR	1,325	97.3
Grande Ronde Hospital	La Grande	OR	498	94.4
Lake District Hospital	Lakeview	OR	145	90.7
Midvalley Healthcare/Samaritan Lebanon Community Hospital	Lebanon	OR	514	94.0
Samaritan North Lincoln Hospital	Lincoln City	OR	398	89.7
Mountain View Hospital	Madras	OR	162	90.8
Willamette Valley Medical Center	McMinnville	OR	563	92.3
Providence Medford Medical Center	Medford	OR	1,214	92.3
Rogue Valley Medical Center	Medford	OR	1,476	91.2
Providence Newberg Hospital	Newberg	OR	173	90.1
Samaritan Pacific Communities Hospital	Newport	OR	518	89.6
Holy Rosary Medical Center	Ontario	OR	885	94.2
Willamette Falls Hospital	Oregon City	OR	385	89.6
St. Anthony Hospital	Pendleton	OR	395	92.9
Adventist Medical Center	Portland	OR	700	89.2
Eastmoreland Hospital	Portland	OR	418	83.6
Legacy Emanuel Hospital & Health Center	Portland	OR	583	86.0

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 1. Hospital information	
			Number of deaths among chronically ill patients assigned to hospital, 1999-2003	Percent of enrollees' medical inpatient days at hospital to which they were assigned*
Legacy Good Samaritan Hospital & Medical	Portland	OR	1,012	90.3
Legacy Mount Hood Medical Center	Gresham	OR	433	91.6
OHSC Hospital and Clinics	Portland	OR	794	83.9
Providence Milwaukie Hospital	Milwaukie	OR	274	85.3
Providence Portland Medical Center	Portland	OR	1,622	90.2
Providence St. Vincent Medical Center	Portland	OR	1,645	90.9
Woodland Park Hospital	Portland	OR	374	86.4
Pioneer Memorial Hospital	Prineville	OR	226	93.5
Central Oregon District Hospital	Redmond	OR	329	91.7
Mercy Medical Center Inc.	Roseburg	OR	1,602	95.1
Salem Hospital	Salem	OR	2,064	95.3
Santiam Memorial Hospital	Stayton	OR	191	87.6
Providence Seaside Hospital	Seaside	OR	262	87.9
Silverton Hospital	Silverton	OR	301	91.7
McKenzie-Willamette Medical Center	Springfield	OR	673	91.1
Mid-Columbia Medical Center	The Dalles	OR	641	93.8
Tillamook County General Hospital	Tillamook	OR	387	91.0
Legacy Meridian Park Hospital	Tualatin	OR	1,018	92.2

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 2. Medicare reimbursements per decedent during the last two years of life						
			Inpatient + Part B spending**	*Inpatient reimbursements**				*Part B reimbursements***	
				Total	Outlier	% Outlier	Per day	Total	E&M
Samaritan Albany General Hospital	Albany	OR	22,491	16,715	765	4.6	1,312	5,401	2,307
Ashland Community Hospital	Ashland	OR		16,532	1,049	6.3	1,199		
Columbia Memorial Hospital	Astoria	OR	26,913	20,846	989	4.7	1,166	6,191	2,126
St. Elizabeth Health Services Inc.	Baker City	OR	22,635	17,520	808	4.6	1,210	4,959	2,138
St. Charles Medical Center	Bend	OR	27,272	19,531	803	4.1	1,238	7,466	2,762
Harney District Hospital	Burns	OR		23,095	717	3.1	1,441		
Bay Area Hospital	Coos Bay	OR	28,493	20,645	896	4.3	1,178	7,382	2,710
Coquille Valley Hospital	Coquille	OR		16,216	666	4.1	1,385		
Lower Umpqua Hospital	Reedsport	OR		16,201	401	2.5	1,192		
Southern Coos General Hospital	Bandon	OR		21,036	823	3.9	1,530		
Good Samaritan Regional Medical Center	Corvallis	OR	25,774	19,634	1,061	5.4	1,286	6,146	2,421
Valley Community Hospital	Dallas	OR		18,449	1,738	9.4	1,349		
Wallowa Memorial Hospital	Enterprise	OR		17,896	1,136	6.3	1,180		
Sacred Heart Medical Center	Eugene	OR	26,984	18,757	954	5.1	1,276	7,638	2,582
Peace Harbor Hospital	Florence	OR		17,717	490	2.8	1,394		
Curry General Hospital	Gold Beach	OR		22,285	2,406	10.8	1,402		
Three Rivers Community Hospital & Health	Grants Pass	OR	22,725	16,466	875	5.3	1,282	6,159	2,154
Good Shepherd Medical Center	Hermiston	OR	26,731	20,313	1,113	5.5	1,163	6,478	2,424
Tuality Healthcare	Hillsboro	OR	29,542	22,164	1,036	4.7	1,164	6,961	2,892
Providence Hood River Memorial Hospital	Hood River	OR		17,985	899	5.0	1,553		
Blue Mountain Hospital District	John Day	OR		17,869	721	4.0	1,348		
Merle West Medical Center	Klamath Falls	OR	22,393	16,817	805	4.8	1,113	4,944	2,185
Grande Ronde Hospital	La Grande	OR	22,095	17,110	579	3.4	1,244	4,639	1,978
Lake District Hospital	Lakeview	OR		19,109	453	2.4	1,388		
Midvalley Healthcare/Samaritan Lebanon Community Hospital	Lebanon	OR	21,157	16,162	849	5.3	1,128	4,512	1,963
Samaritan North Lincoln Hospital	Lincoln City	OR		19,275	333	1.7	1,567		
Mountain View Hospital	Madras	OR		16,983	619	3.6	1,376		
Willamette Valley Medical Center	McMinnville	OR	30,067	22,098	1,123	5.1	1,288	7,760	2,749
Providence Medford Medical Center	Medford	OR	25,950	17,788	1,436	8.1	1,185	7,719	2,500
Rogue Valley Medical Center	Medford	OR	26,461	18,790	1,469	7.8	1,219	7,562	2,732
Providence Newberg Hospital	Newberg	OR		19,798	1,190	6.0	1,438		
Samaritan Pacific Communities Hospital	Newport	OR	26,764	20,203	751	3.7	1,436	5,782	2,383
Holy Rosary Medical Center	Ontario	OR	21,845	15,988	701	4.4	1,112	5,493	2,175
Willamette Falls Hospital	Oregon City	OR		17,716	970	5.5	1,246		
St. Anthony Hospital	Pendleton	OR		17,564	694	3.9	1,151		
Adventist Medical Center	Portland	OR	26,173	19,102	778	4.1	1,325	7,197	2,944
Eastmoreland Hospital	Portland	OR	35,923	27,941	1,838	6.6	1,211	8,387	3,111
Legacy Emanuel Hospital & Health Center	Portland	OR	29,864	22,943	1,218	5.3	1,533	6,382	2,229

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 2. Medicare reimbursements per decedent during the last two years of life						
			Inpatient + Part B spending**	*Inpatient reimbursements**				*Part B reimbursements***	
				Total	Outlier	% Outlier	Per day	Total	E&M
Legacy Good Samaritan Hospital & Medical	Portland	OR	33,655	23,804	1,291	5.4	1,331	9,454	2,947
Legacy Mount Hood Medical Center	Gresham	OR	25,755	19,013	1,011	5.3	1,446	6,579	2,426
OHSC Hospital and Clinics	Portland	OR	41,108	34,888	2,267	6.5	1,767	5,853	2,652
Providence Milwaukie Hospital	Milwaukie	OR		18,116	654	3.6	1,516		
Providence Portland Medical Center	Portland	OR	28,884	20,403	530	2.6	1,266	8,106	2,738
Providence St. Vincent Medical Center	Portland	OR	29,637	21,229	918	4.3	1,235	8,580	2,830
Woodland Park Hospital	Portland	OR		22,556	1,098	4.9	1,267		
Pioneer Memorial Hospital	Prineville	OR		12,955	174	1.3	1,278		
Central Oregon District Hospital	Redmond	OR		17,884	493	2.8	1,477		
Mercy Medical Center Inc.	Roseburg	OR	26,758	18,752	641	3.4	1,172	7,910	2,568
Salem Hospital	Salem	OR	27,090	19,043	1,363	7.2	1,101	7,725	2,757
Santiam Memorial Hospital	Stayton	OR		21,536	1,281	5.9	1,182		
Providence Seaside Hospital	Seaside	OR		22,579	401	1.8	1,378		
Silverton Hospital	Silverton	OR		17,920	849	4.7	1,312		
McKenzie-Willamette Medical Center	Springfield	OR	25,864	18,248	925	5.1	1,285	6,967	2,428
Mid-Columbia Medical Center	The Dalles	OR	28,863	22,199	1,369	6.2	1,342	5,673	2,557
Tillamook County General Hospital	Tillamook	OR		18,770	227	1.2	1,306		
Legacy Meridian Park Hospital	Tualatin	OR	28,610	19,923	869	4.4	1,317	8,446	2,987

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Hospital Name	City	State	Table 3a. The Medical Care Cost Equation: Disaggregation of inpatient reimbursements per decedent into contributions of volume (patient days per decedent) and price (average reimbursements per day in hospital) during the last two years of life							
						*Ratios to U.S. average**				
			Inpatient reimbursements per decedent*	Hospital days per decedent*	Reimbursements per patient day*	Inpatient reimbursements	=	Hospital days	x	Reimbursements per day
Samaritan Albany General Hospital	Albany	OR	16,715	12.7	1,312	0.68	=	0.53	x	1.28
Ashland Community Hospital	Ashland	OR	16,532	13.8	1,199	0.68	=	0.58	x	1.17
Columbia Memorial Hospital	Astoria	OR	20,846	17.9	1,166	0.85	=	0.75	x	1.14
St. Elizabeth Health Services Inc.	Baker City	OR	17,520	14.5	1,210	0.72	=	0.61	x	1.18
St. Charles Medical Center	Bend	OR	19,531	15.8	1,238	0.80	=	0.66	x	1.21
Harney District Hospital	Burns	OR	23,095	16.0	1,441	0.94	=	0.67	x	1.41
Bay Area Hospital	Coos Bay	OR	20,645	17.5	1,178	0.84	=	0.73	x	1.15
Coquille Valley Hospital	Coquille	OR	16,216	11.7	1,385	0.66	=	0.49	x	1.35
Lower Umpqua Hospital	Reedsport	OR	16,201	13.6	1,192	0.66	=	0.57	x	1.16
Southern Coos General Hospital	Bandon	OR	21,036	13.7	1,530	0.86	=	0.57	x	1.49
Good Samaritan Regional Medical Center	Corvallis	OR	19,634	15.3	1,286	0.80	=	0.64	x	1.26
Valley Community Hospital	Dallas	OR	18,449	13.7	1,349	0.75	=	0.57	x	1.32
Wallowa Memorial Hospital	Enterprise	OR	17,896	15.2	1,180	0.73	=	0.63	x	1.15
Sacred Heart Medical Center	Eugene	OR	18,757	14.7	1,276	0.77	=	0.61	x	1.25
Peace Harbor Hospital	Florence	OR	17,717	12.7	1,394	0.72	=	0.53	x	1.36
Curry General Hospital	Gold Beach	OR	22,285	15.9	1,402	0.91	=	0.66	x	1.37
Three Rivers Community Hospital & Health	Grants Pass	OR	16,466	12.8	1,282	0.67	=	0.54	x	1.25
Good Shepherd Medical Center	Hermiston	OR	20,313	17.5	1,163	0.83	=	0.73	x	1.14
Tuality Healthcare	Hillsboro	OR	22,164	19.0	1,164	0.90	=	0.80	x	1.14
Providence Hood River Memorial Hospital	Hood River	OR	17,985	11.6	1,553	0.73	=	0.48	x	1.52
Blue Mountain Hospital District	John Day	OR	17,869	13.3	1,348	0.73	=	0.55	x	1.32
Merle West Medical Center	Klamath Falls	OR	16,817	15.1	1,113	0.69	=	0.63	x	1.09
Grande Ronde Hospital	La Grande	OR	17,110	13.8	1,244	0.70	=	0.57	x	1.22
Lake District Hospital	Lakeview	OR	19,109	13.8	1,388	0.78	=	0.58	x	1.36
Midvalley Healthcare/Samaritan Lebanon Community Hospital	Lebanon	OR	16,162	14.3	1,128	0.66	=	0.60	x	1.10
Samaritan North Lincoln Hospital	Lincoln City	OR	19,275	12.3	1,567	0.79	=	0.51	x	1.53
Mountain View Hospital	Madras	OR	16,983	12.3	1,376	0.69	=	0.52	x	1.34
Willamette Valley Medical Center	McMinnville	OR	22,098	17.2	1,288	0.90	=	0.72	x	1.26
Providence Medford Medical Center	Medford	OR	17,788	15.0	1,185	0.73	=	0.63	x	1.16
Rogue Valley Medical Center	Medford	OR	18,790	15.4	1,219	0.77	=	0.64	x	1.19
Providence Newberg Hospital	Newberg	OR	19,798	13.8	1,438	0.81	=	0.58	x	1.41
Samaritan Pacific Communities Hospital	Newport	OR	20,203	14.1	1,436	0.82	=	0.59	x	1.40
Holy Rosary Medical Center	Ontario	OR	15,988	14.4	1,112	0.65	=	0.60	x	1.09
Willamette Falls Hospital	Oregon City	OR	17,716	14.2	1,246	0.72	=	0.59	x	1.22
St. Anthony Hospital	Pendleton	OR	17,564	15.3	1,151	0.72	=	0.64	x	1.12
Adventist Medical Center	Portland	OR	19,102	14.4	1,325	0.78	=	0.60	x	1.29
Eastmoreland Hospital	Portland	OR	27,941	23.1	1,211	1.14	=	0.96	x	1.18
Legacy Emanuel Hospital & Health Center	Portland	OR	22,943	15.0	1,533	0.94	=	0.63	x	1.50

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Hospital Name	City	State	Table 3a. The Medical Care Cost Equation: Disaggregation of inpatient reimbursements per decedent into contributions of volume (patient days per decedent) and price (average reimbursements per day in hospital) during the last two years of life							
			Inpatient reimbursements per decedent*	Hospital days per decedent*	Reimbursements per patient day*	*Ratios to U.S. average**				
						Inpatient reimbursements	=	Hospital days	x	Reimbursements per day
Legacy Good Samaritan Hospital & Medical	Portland	OR	23,804	17.9	1,331	0.97	=	0.75	x	1.30
Legacy Mount Hood Medical Center	Gresham	OR	19,013	13.2	1,446	0.78	=	0.55	x	1.41
OHSC Hospital and Clinics	Portland	OR	34,888	19.7	1,767	1.42	=	0.83	x	1.73
Providence Milwaukie Hospital	Milwaukie	OR	18,116	11.9	1,516	0.74	=	0.50	x	1.48
Providence Portland Medical Center	Portland	OR	20,403	16.1	1,266	0.83	=	0.67	x	1.24
Providence St. Vincent Medical Center	Portland	OR	21,229	17.2	1,235	0.87	=	0.72	x	1.21
Woodland Park Hospital	Portland	OR	22,556	17.8	1,267	0.92	=	0.74	x	1.24
Pioneer Memorial Hospital	Prineville	OR	12,955	10.1	1,278	0.53	=	0.42	x	1.25
Central Oregon District Hospital	Redmond	OR	17,884	12.1	1,477	0.73	=	0.51	x	1.44
Mercy Medical Center Inc.	Roseburg	OR	18,752	16.0	1,172	0.77	=	0.67	x	1.14
Salem Hospital	Salem	OR	19,043	17.3	1,101	0.78	=	0.72	x	1.08
Santiam Memorial Hospital	Stayton	OR	21,536	18.2	1,182	0.88	=	0.76	x	1.15
Providence Seaside Hospital	Seaside	OR	22,579	16.4	1,378	0.92	=	0.68	x	1.35
Silverton Hospital	Silverton	OR	17,920	13.7	1,312	0.73	=	0.57	x	1.28
McKenzie-Willamette Medical Center	Springfield	OR	18,248	14.2	1,285	0.75	=	0.59	x	1.26
Mid-Columbia Medical Center	The Dalles	OR	22,199	16.5	1,342	0.91	=	0.69	x	1.31
Tillamook County General Hospital	Tillamook	OR	18,770	14.4	1,306	0.77	=	0.60	x	1.28
Legacy Meridian Park Hospital	Tualatin	OR	19,923	15.1	1,317	0.81	=	0.63	x	1.29

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Hospital Name	City	State	Table 3b. The Medical Care Cost Equation: Disaggregation of reimbursements for evaluation and management per decedent into contributions of volume (physician visits per decedent) and price (average E&M payments per physician visit) during the last two years of life							
			E&M reimbursements per decedent**	Physician visits per decedent**	E&M reimbursements per visit**	*Ratios to U.S. average***				
						E&M reimbursements	=	Physician visits	x	Reimbursements per visit
Samaritan Albany General Hospital	Albany	OR	2,307	36.6	63	0.59	=	0.55	x	1.08
Ashland Community Hospital	Ashland	OR								
Columbia Memorial Hospital	Astoria	OR	2,126	35.6	60	0.54	=	0.53	x	1.02
St. Elizabeth Health Services Inc.	Baker City	OR	2,138	38.4	56	0.55	=	0.58	x	0.95
St. Charles Medical Center	Bend	OR	2,762	46.2	60	0.71	=	0.69	x	1.02
Harney District Hospital	Burns	OR								
Bay Area Hospital	Coos Bay	OR	2,710	48.3	56	0.69	=	0.72	x	0.96
Coquille Valley Hospital	Coquille	OR								
Lower Umpqua Hospital	Reedsport	OR								
Southern Coos General Hospital	Bandon	OR								
Good Samaritan Regional Medical Center	Corvallis	OR	2,421	41.2	59	0.62	=	0.62	x	1.01
Valley Community Hospital	Dallas	OR								
Wallowa Memorial Hospital	Enterprise	OR								
Sacred Heart Medical Center	Eugene	OR	2,582	43.5	59	0.66	=	0.65	x	1.01
Peace Harbor Hospital	Florence	OR								
Curry General Hospital	Gold Beach	OR								
Three Rivers Community Hospital & Health	Grants Pass	OR	2,154	35.8	60	0.55	=	0.54	x	1.03
Good Shepherd Medical Center	Hermiston	OR	2,424	38.5	63	0.62	=	0.58	x	1.08
Tuality Healthcare	Hillsboro	OR	2,892	53.8	54	0.74	=	0.81	x	0.92
Providence Hood River Memorial Hospital	Hood River	OR								
Blue Mountain Hospital District	John Day	OR								
Merle West Medical Center	Klamath Falls	OR	2,185	42.0	52	0.56	=	0.63	x	0.89
Grande Ronde Hospital	La Grande	OR	1,978	36.6	54	0.51	=	0.55	x	0.92
Lake District Hospital	Lakeview	OR								
Midvalley Healthcare/Samaritan Lebanon Community Hospital	Lebanon	OR	1,963	37.5	52	0.50	=	0.56	x	0.90
Samaritan North Lincoln Hospital	Lincoln City	OR								
Mountain View Hospital	Madras	OR								
Willamette Valley Medical Center	McMinnville	OR	2,749	49.7	55	0.70	=	0.74	x	0.95
Providence Medford Medical Center	Medford	OR	2,500	41.9	60	0.64	=	0.63	x	1.02
Rogue Valley Medical Center	Medford	OR	2,732	44.7	61	0.70	=	0.67	x	1.05
Providence Newberg Hospital	Newberg	OR								
Samaritan Pacific Communities Hospital	Newport	OR	2,383	39.5	60	0.61	=	0.59	x	1.03
Holy Rosary Medical Center	Ontario	OR	2,175	36.8	59	0.56	=	0.55	x	1.01
Willamette Falls Hospital	Oregon City	OR								
St. Anthony Hospital	Pendleton	OR								
Adventist Medical Center	Portland	OR	2,944	40.7	72	0.75	=	0.61	x	1.24
Eastmoreland Hospital	Portland	OR	3,111	48.4	64	0.80	=	0.73	x	1.10
Legacy Emanuel Hospital & Health Center	Portland	OR	2,229	33.9	66	0.57	=	0.51	x	1.12

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Hospital Name	City	State	Table 3b. The Medical Care Cost Equation: Disaggregation of reimbursements for evaluation and management per decedent into contributions of volume (physician visits per decedent) and price (average E&M payments per physician visit) during the last two years of life							
			E&M reimbursements per decedent**	Physician visits per decedent**	E&M reimbursements per visit**	*Ratios to U.S. average***				
						E&M reimbursements	=	Physician visits	x	Reimbursements per visit
Legacy Good Samaritan Hospital & Medical	Portland	OR	2,947	48.3	61	0.76	=	0.72	x	1.04
Legacy Mount Hood Medical Center	Gresham	OR	2,426	35.5	68	0.62	=	0.53	x	1.17
OHSC Hospital and Clinics	Portland	OR	2,652	40.3	66	0.68	=	0.60	x	1.13
Providence Milwaukie Hospital	Milwaukie	OR								
Providence Portland Medical Center	Portland	OR	2,738	44.3	62	0.70	=	0.66	x	1.06
Providence St. Vincent Medical Center	Portland	OR	2,830	46.2	61	0.73	=	0.69	x	1.05
Woodland Park Hospital	Portland	OR								
Pioneer Memorial Hospital	Prineville	OR								
Central Oregon District Hospital	Redmond	OR								
Mercy Medical Center Inc.	Roseburg	OR	2,568	44.4	58	0.66	=	0.67	x	0.99
Salem Hospital	Salem	OR	2,757	48.3	57	0.71	=	0.72	x	0.98
Santiam Memorial Hospital	Stayton	OR								
Providence Seaside Hospital	Seaside	OR								
Silverton Hospital	Silverton	OR								
McKenzie-Willamette Medical Center	Springfield	OR	2,428	44.5	55	0.62	=	0.67	x	0.93
Mid-Columbia Medical Center	The Dalles	OR	2,557	43.0	59	0.66	=	0.64	x	1.02
Tillamook County General Hospital	Tillamook	OR								
Legacy Meridian Park Hospital	Tualatin	OR	2,987	45.1	66	0.77	=	0.68	x	1.13

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 4. Resource inputs per 1,000 decedents during the last two years of life					
					*Standardized FTE physician labor***			
			Hospital beds*	Intensive care beds*	Total	Primary care	Medical specialists	Ratio PC/MS
Samaritan Albany General Hospital	Albany	OR	34.9	6.0	16.1	9.6	3.7	2.58
Ashland Community Hospital	Ashland	OR	37.8	4.0				
Columbia Memorial Hospital	Astoria	OR	49.0	10.3	15.3	9.5	3.0	3.17
St. Elizabeth Health Services Inc.	Baker City	OR	39.7	5.0	14.7	7.9	3.4	2.33
St. Charles Medical Center	Bend	OR	43.2	3.7	18.7	6.7	7.9	0.85
Harney District Hospital	Burns	OR	43.9	3.1				
Bay Area Hospital	Coos Bay	OR	48.0	16.4	20.4	12.0	3.6	3.37
Coquille Valley Hospital	Coquille	OR	32.1	3.8				
Lower Umpqua Hospital	Reedsport	OR	37.2	6.0				
Southern Coos General Hospital	Bandon	OR	37.7	6.5				
Good Samaritan Regional Medical Center	Corvallis	OR	41.8	4.5	17.7	8.9	5.3	1.67
Valley Community Hospital	Dallas	OR	37.5	16.9				
Wallowa Memorial Hospital	Enterprise	OR	41.5	6.0				
Sacred Heart Medical Center	Eugene	OR	40.3	9.8	18.4	8.0	6.5	1.23
Peace Harbor Hospital	Florence	OR	34.8	6.9				
Curry General Hospital	Gold Beach	OR	43.5	8.6				
Three Rivers Community Hospital & Health	Grants Pass	OR	35.2	5.6	15.7	8.8	3.3	2.71
Good Shepherd Medical Center	Hermiston	OR	47.8	7.7	16.2	8.8	3.7	2.37
Tuality Healthcare	Hillsboro	OR	52.2	13.8	21.0	7.4	9.6	0.77
Providence Hood River Memorial Hospital	Hood River	OR	31.7	5.9				
Blue Mountain Hospital District	John Day	OR	36.3	4.1				
Merle West Medical Center	Klamath Falls	OR	41.4	9.6	15.2	6.4	5.1	1.26
Grande Ronde Hospital	La Grande	OR	37.7	7.0	14.8	9.6	1.8	5.37
Lake District Hospital	Lakeview	OR	37.7	8.1				
Midvalley Healthcare/Samaritan Lebanon Community Hospital	Lebanon	OR	39.3	5.9	13.1	8.0	2.8	2.85
Samaritan North Lincoln Hospital	Lincoln City	OR	33.7	4.2				
Mountain View Hospital	Madras	OR	33.8	2.6				
Willamette Valley Medical Center	McMinnville	OR	47.0	5.9	20.7	11.0	4.9	2.22
Providence Medford Medical Center	Medford	OR	41.1	4.6	16.8	6.9	5.7	1.21
Rogue Valley Medical Center	Medford	OR	42.2	6.6	17.9	6.5	7.7	0.84
Providence Newberg Hospital	Newberg	OR	37.7	6.2				
Samaritan Pacific Communities Hospital	Newport	OR	38.5	7.5	16.7	11.0	2.5	4.43
Holy Rosary Medical Center	Ontario	OR	39.4	7.1	17.6	7.6	5.3	1.44
Willamette Falls Hospital	Oregon City	OR	38.9	4.6				
St. Anthony Hospital	Pendleton	OR	41.8	6.5				
Adventist Medical Center	Portland	OR	39.5	5.5	18.3	7.2	7.3	0.99
Eastmoreland Hospital	Portland	OR	63.2	4.7	20.0	7.0	6.5	1.08
Legacy Emanuel Hospital & Health Center	Portland	OR	41.0	6.9	14.6	5.8	5.3	1.11

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 4. Resource inputs per 1,000 decedents during the last two years of life					
					*Standardized FTE physician labor***			
			Hospital beds*	Intensive care beds*	Total	Primary care	Medical specialists	Ratio PC/MS
Legacy Good Samaritan Hospital & Medical	Portland	OR	49.0	5.9	19.8	6.3	9.0	0.70
Legacy Mount Hood Medical Center	Gresham	OR	36.0	7.0	15.9	5.8	6.4	0.92
OHSC Hospital and Clinics	Portland	OR	54.1	11.9	17.7	6.5	6.9	0.94
Providence Milwaukie Hospital	Milwaukie	OR	32.7	5.5				
Providence Portland Medical Center	Portland	OR	44.1	4.4	19.0	7.0	6.9	1.02
Providence St. Vincent Medical Center	Portland	OR	47.1	5.9	19.4	8.0	7.1	1.13
Woodland Park Hospital	Portland	OR	48.8	5.3				
Pioneer Memorial Hospital	Prineville	OR	27.8	4.7				
Central Oregon District Hospital	Redmond	OR	33.2	5.2				
Mercy Medical Center Inc.	Roseburg	OR	43.9	12.0	17.9	6.9	7.2	0.97
Salem Hospital	Salem	OR	47.4	14.6	19.7	7.1	7.9	0.90
Santiam Memorial Hospital	Stayton	OR	49.9	8.5				
Providence Seaside Hospital	Seaside	OR	44.9	5.4				
Silverton Hospital	Silverton	OR	37.4	7.1				
McKenzie-Willamette Medical Center	Springfield	OR	38.9	8.4	18.4	9.5	5.4	1.76
Mid-Columbia Medical Center	The Dalles	OR	45.3	12.0	18.6	10.0	4.2	2.37
Tillamook County General Hospital	Tillamook	OR	39.4	4.1				
Legacy Meridian Park Hospital	Tualatin	OR	41.4	7.6	18.8	7.8	7.6	1.02

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 5. Utilization per decedent during the last six months of life					
					*Physician visits***			
			Hospital days*	Intensive care days*	Total	Primary care	Medical specialist	Ratio MS/PC
Samaritan Albany General Hospital	Albany	OR	7.1	1.4	15.3	11.5	2.9	0.25
Ashland Community Hospital	Ashland	OR	7.3	0.8				
Columbia Memorial Hospital	Astoria	OR	10.9	2.4	17.7	13.3	3.5	0.27
St. Elizabeth Health Services Inc.	Baker City	OR	7.4	0.9	18.4	13.7	3.0	0.22
St. Charles Medical Center	Bend	OR	8.9	0.9	21.0	9.1	10.6	1.17
Harney District Hospital	Burns	OR	9.4	0.7				
Bay Area Hospital	Coos Bay	OR	9.9	3.4	21.2	14.9	4.6	0.31
Coquille Valley Hospital	Coquille	OR	6.2	0.6				
Lower Umpqua Hospital	Reedsport	OR	7.3	1.2				
Southern Coos General Hospital	Bandon	OR	8.0	1.5				
Good Samaritan Regional Medical Center	Corvallis	OR	8.9	1.0	19.5	13.3	5.6	0.42
Valley Community Hospital	Dallas	OR	7.1	3.2				
Wallowa Memorial Hospital	Enterprise	OR	9.1	1.5				
Sacred Heart Medical Center	Eugene	OR	8.2	2.0	19.4	11.7	6.4	0.54
Peace Harbor Hospital	Florence	OR	6.8	1.6				
Curry General Hospital	Gold Beach	OR	9.4	2.2				
Three Rivers Community Hospital & Health	Grants Pass	OR	7.5	1.3	15.2	11.6	2.7	0.23
Good Shepherd Medical Center	Hermiston	OR	10.5	1.8	18.0	12.4	4.5	0.36
Tuality Healthcare	Hillsboro	OR	10.5	3.1	26.0	9.2	14.6	1.58
Providence Hood River Memorial Hospital	Hood River	OR	6.8	1.4				
Blue Mountain Hospital District	John Day	OR	7.2	1.0				
Merle West Medical Center	Klamath Falls	OR	8.4	2.0	17.9	9.8	6.9	0.70
Grande Ronde Hospital	La Grande	OR	7.2	1.3	14.8	12.3	1.7	0.14
Lake District Hospital	Lakeview	OR	7.5	1.8				
Midvalley Healthcare/Samaritan Lebanon Community Hospital	Lebanon	OR	8.4	1.4	18.0	14.3	3.0	0.21
Samaritan North Lincoln Hospital	Lincoln City	OR	6.9	0.9				
Mountain View Hospital	Madras	OR	7.2	0.6				
Willamette Valley Medical Center	McMinnville	OR	9.6	1.3	22.2	16.2	4.7	0.29
Providence Medford Medical Center	Medford	OR	8.5	1.0	17.3	9.3	7.1	0.76
Rogue Valley Medical Center	Medford	OR	9.0	1.6	19.7	8.5	10.2	1.19
Providence Newberg Hospital	Newberg	OR	7.7	1.4				
Samaritan Pacific Communities Hospital	Newport	OR	7.6	1.7	18.2	14.6	2.8	0.19
Holy Rosary Medical Center	Ontario	OR	8.1	1.7	16.4	8.2	6.3	0.77
Willamette Falls Hospital	Oregon City	OR	8.3	1.1				
St. Anthony Hospital	Pendleton	OR	8.4	1.4				
Adventist Medical Center	Portland	OR	8.6	1.5	19.3	10.0	8.2	0.82
Eastmoreland Hospital	Portland	OR	10.5	1.0	18.8	8.5	6.2	0.73
Legacy Emanuel Hospital & Health Center	Portland	OR	9.3	1.8	18.0	9.1	7.0	0.76

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 5. Utilization per decedent during the last six months of life					
					*Physician visits***			
			Hospital days*	Intensive care days*	Total	Primary care	Medical specialist	Ratio MS/PC
Legacy Good Samaritan Hospital & Medical	Portland	OR	10.0	1.3	24.3	10.6	12.0	1.14
Legacy Mount Hood Medical Center	Gresham	OR	8.1	1.9	16.8	7.5	8.0	1.07
OHSC Hospital and Clinics	Portland	OR	12.0	3.1	20.3	9.2	8.7	0.95
Providence Milwaukie Hospital	Milwaukie	OR	7.0	1.2				
Providence Portland Medical Center	Portland	OR	9.3	1.0	21.1	10.1	9.6	0.95
Providence St. Vincent Medical Center	Portland	OR	10.1	1.5	21.6	10.1	10.2	1.01
Woodland Park Hospital	Portland	OR	9.7	1.4				
Pioneer Memorial Hospital	Prineville	OR	5.6	1.0				
Central Oregon District Hospital	Redmond	OR	6.5	1.1				
Mercy Medical Center Inc.	Roseburg	OR	9.1	2.8	20.0	9.9	8.7	0.88
Salem Hospital	Salem	OR	10.1	3.2	22.5	9.8	10.5	1.08
Santiam Memorial Hospital	Stayton	OR	11.1	1.9				
Providence Seaside Hospital	Seaside	OR	9.4	1.3				
Silverton Hospital	Silverton	OR	7.7	1.6				
McKenzie-Willamette Medical Center	Springfield	OR	8.0	1.8	21.8	15.2	5.6	0.37
Mid-Columbia Medical Center	The Dalles	OR	9.2	2.6	18.9	14.2	3.2	0.22
Tillamook County General Hospital	Tillamook	OR	8.0	0.9				
Legacy Meridian Park Hospital	Tualatin	OR	8.2	1.4	20.2	9.8	9.0	0.92

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**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 6. Quality measures						
			*Intensity of terminal care**		% seeing 10 or more physicians (L6M)**	*CMS technical process quality measures****			
			% of deaths with ICU	% admitted to hospice (L6M)		Composite score	AMI score	CHF score	Pneumonia score
Samaritan Albany General Hospital	Albany	OR	12.8	32.9	8.0				
Ashland Community Hospital	Ashland	OR	10.6	51.6					
Columbia Memorial Hospital	Astoria	OR	17.3	27.5	5.6				
St. Elizabeth Health Services Inc.	Baker City	OR	9.3	19.1	12.7				
St. Charles Medical Center	Bend	OR	9.3	48.9	25.4	78.3	85.3	89.5	59.3
Harney District Hospital	Burns	OR	5.3	22.1					
Bay Area Hospital	Coos Bay	OR	19.6	27.5	8.8				
Coquille Valley Hospital	Coquille	OR	3.9	22.4					
Lower Umpqua Hospital	Reedsport	OR	12.1	24.5					
Southern Coos General Hospital	Bandon	OR	8.2	18.5					
Good Samaritan Regional Medical Center	Corvallis	OR	11.0	33.6	16.4				
Valley Community Hospital	Dallas	OR	14.3	19.2					
Wallowa Memorial Hospital	Enterprise	OR	10.6	16.8					
Sacred Heart Medical Center	Eugene	OR	14.0	30.1	24.2	85.2	85.4	86.0	84.3
Peace Harbor Hospital	Florence	OR	11.5	35.9					
Curry General Hospital	Gold Beach	OR	9.1	32.6					
Three Rivers Community Hospital & Health	Grants Pass	OR	11.8	28.7	9.1				
Good Shepherd Medical Center	Hermiston	OR	16.8	15.5	10.0				
Tuality Healthcare	Hillsboro	OR	16.4	27.1	12.9				
Providence Hood River Memorial Hospital	Hood River	OR	13.5	32.3					
Blue Mountain Hospital District	John Day	OR	5.7	19.9					
Merle West Medical Center	Klamath Falls	OR	13.5	30.6	10.0				
Grande Ronde Hospital	La Grande	OR	14.0	28.9	8.1				
Lake District Hospital	Lakeview	OR	13.1	20.6					
Midvalley Healthcare/Samaritan Lebanon Community Hospital	Lebanon	OR	15.9	22.1	10.5				
Samaritan North Lincoln Hospital	Lincoln City	OR	10.1	23.0					
Mountain View Hospital	Madras	OR	5.0	42.0					
Willamette Valley Medical Center	McMinnville	OR	11.5	43.5	15.5				
Providence Medford Medical Center	Medford	OR	10.4	45.4	15.1				
Rogue Valley Medical Center	Medford	OR	13.0	48.4	17.4	81.3	92.4	83.5	61.3
Providence Newberg Hospital	Newberg	OR	12.3	42.1					
Samaritan Pacific Communities Hospital	Newport	OR	13.6	27.9	15.9				
Holy Rosary Medical Center	Ontario	OR	14.6	37.3	11.0				
Willamette Falls Hospital	Oregon City	OR	13.3	36.5					
St. Anthony Hospital	Pendleton	OR	16.9	21.1					
Adventist Medical Center	Portland	OR	15.2	41.3	25.8	90.6	97.8	96.0	75.0
Eastmoreland Hospital	Portland	OR	11.4	38.2	10.5				
Legacy Emanuel Hospital & Health Center	Portland	OR	17.0	38.0	22.3				

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**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Performance report for chronically ill beneficiaries in traditional Medicare: Hospitals

Hospital Name	City	State	Table 6. Quality measures						
			*Intensity of terminal care**		% seeing 10 or more physicians (L6M)**	*CMS technical process quality measures****			
			% of deaths with ICU	% admitted to hospice (L6M)		Composite score	AMI score	CHF score	Pneumonia score
Legacy Good Samaritan Hospital & Medical	Portland	OR	14.0	38.8	30.3	88.1	93.6	95.5	74.0
Legacy Mount Hood Medical Center	Gresham	OR	16.3	29.6	14.4				
OHSC Hospital and Clinics	Portland	OR	21.4	35.5	33.2	86.8	98.5	95.0	61.7
Providence Milwaukie Hospital	Milwaukie	OR	15.9	32.0					
Providence Portland Medical Center	Portland	OR	14.5	36.7	28.7	84.7	97.0	79.5	67.7
Providence St. Vincent Medical Center	Portland	OR	15.2	33.3	27.5	81.4	93.2	70.5	69.0
Woodland Park Hospital	Portland	OR	13.0	27.1					
Pioneer Memorial Hospital	Prineville	OR	9.2	56.2					
Central Oregon District Hospital	Redmond	OR	8.8	56.5					
Mercy Medical Center Inc.	Roseburg	OR	17.9	32.7	20.5	81.3	95.5	80.0	58.3
Salem Hospital	Salem	OR	17.0	30.2	23.3	72.0	81.8	71.0	56.3
Santiam Memorial Hospital	Stayton	OR	9.0	25.6					
Providence Seaside Hospital	Seaside	OR	13.6	26.6					
Silverton Hospital	Silverton	OR	11.5	31.7					
McKenzie-Willamette Medical Center	Springfield	OR	14.6	28.7	16.6				
Mid-Columbia Medical Center	The Dalles	OR	15.9	31.1	9.2				
Tillamook County General Hospital	Tillamook	OR	10.0	37.4					
Legacy Meridian Park Hospital	Tualatin	OR	12.7	40.2	19.8	88.3	93.0	97.5	74.3

*Deaths occurring 1999-2003
**Deaths occurring 2000-2003
***All patients. Data are for Q1-Q2, 2004

Vermont Pilot of Community Based Payment Reform
Accountable Care Organization
Health Care Reform Commission

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As part of the Health Care Reform Commission's review of potential approaches to controlling medical costs, the commission staff has proposed to implement the Accountable Care Organization model as part of broader payment reform. This memo summarizes the Accountable Care Organization concept, describes how the concept might be translated into a pilot in one or two communities in Vermont, and concludes with a discussion of key questions regarding the design and implementation of the Vermont pilot, and the next steps in answering those questions. This will serve as the framework for potential legislation in the 2008 session which would be part of a larger health reform package. The intent is to authorize a more detailed design of the pilot and formulation of an implementation plan which would be initiated in early 2009 with a target start up date in early 2010.

This proposal complements the pilot in payment reform for chronic illness services which is currently being designed for the Blueprint for Health. The Medical Home model proposed for the Blueprint pilot is quite consistent with the ACO framework, but addresses only payment to primary care physicians. The ACO model is designed at a higher level to include payments for all services to a given population. A second, complementary effort by the commission is the review of the annual hospital budget review process by the Public Oversight Commission and BISHCA. That initiative is focused on trying to create more effective incentives for cost control in hospital based care.

Background: What is an Accountable Care Organization?

In testimony before the House Health Care Committee last spring, Elliott Fisher introduced the concept of an Accountable Care Organization. The ACO would be a vehicle for enabling a regional health care delivery system composed of key providers of primary and secondary care within a community to foster a shared accountability for both the costs and quality of care of the population they serve. The ACO would have financial incentives to recapture part of the savings realized by operating more effectively, e.g. reducing the volume of questionable surgical procedures, and to avoid future capacity driven growth. These incentives would reward effective population based care, rather than high margin specialized services. The ACO could use part of its shared savings to reallocate resources to under funded components such as support for chronic illness care or information technology.

According to Elliot, an ACO should

1. be large enough to support comprehensive performance measurement of both cost and quality measures, and a population based budget. This is critical to being able

to document for patients that less care can in fact be better care. We will build on the IHI Triple Aim performance measures of population health, total per capita cost and patient experience
2. provide or effectively manage the full continuum of patient care, outpatient and inpatient to ensure accountability across sites of care
3. participate in shared-savings approaches to payment reform as an interim step toward fundamental payment reform.

He list several examples of possible ACO's including large, multi-specialty group practices which own their own hospitals (Lahey Clinic, Mayo Clinic), Physician Hospital Organizations, and Extended Hospital Medical Staff 's.

Design of a Vermont ACO Pilot

The following is one approach that could be used to create an ACO on a pilot basis within a couple of Vermont communities, using existing organizations such as mature PHO's and hospitals which are restructuring to a FQHC model.

1. Define the local community:
   - Loosely defined as a hospital service area for one of the acute care hospitals.
   - Local delivery system is the hospital, medical staff with privileges at the hospital, nursing homes, visiting nurse services, ancillary service providers, and behavioral health.
   - Population defined in terms of the people using the local primary care providers as their principal source of primary care. If people were required to designate a primary care physician, it would help, but this is problematic. There would be 'leakage' into and out of the local system, with some residents going to another community and some non residents coming in.
   - Possible methods for attributing a population to the ACO: 1) use medical home model with possible 'enrollment' or buy in by patients, 2) use Medicare model of predominance of non inpatient visits, 3) other?

2. Define the payment model:
   - Begin with three major commercial insurers (Blue Cross, MVP, and CIGNA) and Medicaid, with intention of expanding to Medicare through a targeted demonstration project within two years.
   - Incentive based on a global budget developed from an 'actuarially based' per member per month global 'capitation' for an all inclusive menu of services, multiplied times an ACO population.
   - Services would continue to be paid on a fee for service basis using the current contracts for each payer, so there would not be a common fee schedule.
   - Financial settlement: periodically the total actual expenses of the ACO's population for all the services they have used would be compared to the global budget. Actual expenses would include care provided outside of the ACO by other providers, such as tertiary hospitals. If the actual expense were under budget, the payers participating in the pilot would share those savings with the ACO by making a lump sum payment to it. The specific's of how to share the savings are an art form, with possible variations ranging from the most simplistic

(50/50 between payers and ACO) to complex options involving multiple corridors, caps on payments, etc.
- This is NOT a capitation model, but it may be useful to include limited risk if expenses exceed budget.
- The ACO would have the flexibility to allocate its share of the savings between the providers in the ACO and structural improvements such as EMR's.
- Pilot community would initially involve three major commercial payers and Medicaid using the same model, with hope of involving Medicare at some point in future
- ACO would have regular reports on total expenses compared to budget. Reporting could be based on compiling data from four payers, or possibly on the all payer claims data base being created by BISHCA

3. Build local ACO infrastructure
- Limit the ACO initially to a community hospital and its local network of affiliated physicians and other providers
- select a community that already has a functioning Physician Hospital Organization (PHO) which has had a risk sharing contract with MVP and/or Blue Cross for a number of years. It needs to have demonstrated the capability to bring at least one community hospital and local physicians to the table for meaningful conversations about resource use in the community. Potential candidates are
    - Northwest Vermont: Vermont Managed Care composed of Fletcher Allen (Burlington), Porter Hospital (Middlebury), Northwest Vermont Medical Center (St Albans) and Copley Hospital (Morrisville)
    - Bennington: United Health Alliance and Southwest Vermont Medical Center
    - Barre: Central Vermont PHO and Central Vermont Medical Center
- Expand the PHO to add key major local providers who are not currently participating

4. Build capacity to design and implement the pilot
- what organization is best suited for administering the pilot?
- what additional resources will be required?

Design issues and process

An initial set of issues/design questions were raised in a first meeting on the pilot ACO proposal. The commission staff will serve as an initial convener to solicit additional input from other key stakeholders, particularly the payers, PHO's and medical society. This will be translated into a specific option to spend 2008 designing the details of an ACO pilot with a decision on whether or not to proceed occurring in early 2009.

What scale is needed to be able to test the concept? What size of population would be a minimum threshold?
- Does leakage to and from the community across state boundaries pose a major problem in meeting this scale

- Is it really feasible without participation of Medicare? If Medicare is not participating initially, can the combination of major commercial payers and Medicaid have sufficient impact?
- What is the minimum time commitment required to provide a real incentive to drive change? (3 yrs? 5yrs? 10 yrs?)

How link (attribute) the population to the delivery system?

- by historical use patterns (PGP demo)
- by formal 'enrollment' of patients so that they acknowledge their 'medical home'

Payment model/incentives

- How often would there be a reconciliation of experience and payment of incentive (annual?)
- Scope of included services: Would it extend to behavioral health?
- should we follow PGP demonstration model and have part of the ACO payment based on a set of quality measures?

What can we learn from

- Physician Group Practice Medicare demonstration: (see the Commonwealth Fund report at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=428880
- Vermont specific data on population based cost and utilization - opportunities for savings/improvement?
- Efforts in other states (New Jersey, Oregon) to implement the ACO

Funding: what are the opportunities for external funding for design and/or implementation?

Oregon Health Fund Board Delivery Systems Committee
Cost Containment Strategies
FOR DISCUSSION ONLY 3/13/08

Goal: Adjust Supply of Care Through Incentives to Encourage Provision of Effective and Efficient Care

Strategy	Possible Approaches	Target	Long-Term or Short-Term
Targeted Capital Investment	Redesign certificate of need or establish alternative program to effectively control costs, reduce duplicative services and encourage investments in primary care	Providers	Long-Term
	Creation of centers of excellence program	Providers	Long-Term
	Pilot regional health planning organizations	Providers and Communities	Long-Term
Comparative Effectiveness/Medical Technology Assessment	Create collaboration around evaluation of new devises, drugs, procedures and other treatments for comparative effectiveness through expanded role for state's HRC/HSC or through a new entity	All	Long-Term
	Develop and/or endorse clinical guidelines for OHFP providers and widespread statewide adoption	Providers	Long-Term
	Require OHFP plans to design benefits from evidence of added value of treatments and procedures and consistently update using new information	Health Plans	Long-Term
	Pilot projects that require private and public purchasers and health plans to collaborate around joint policies regarding coverage of new technologies and procedures	Health Plans, Purchasers	Long-Term
Provider Payment Strategies Focused on Integrated Health Home (most likely a combination of approaches will be needed)	Bundled per member per month prospective payments for providing integrated health home services (risk adjusted)	Providers	Long-Term
	Capitated payment to integrated health homes to provide all primary care and disease management services (tied to clinical guidelines, risk-adjusted)		
	Pay for Process - Reward providers for providing integrated health home services		
	Pay for Performance - Reward providers for better health outcomes, higher quality and more efficient use of resources		

Goal: Adjust Supply of Care Through Incentives to Encourage Provision of Effective and Efficient Care (Continued)

Strategy	Possible Approaches	Target	Long-Term or Short-Term
Provider Payment Strategies to be Applied to Integrated Health Homes and Across Wider Delivery System	Bundled payments based on episodes of care or portion of episodes of care	Providers	Long-Term
	Condition specific capitation		
	Performance payments for practices able to meet quality goals		
Hospital payments	Hospital pay for performance with bonus payments based on top performance, absolute performance and/or performance improvement	Hospitals	Long-Term

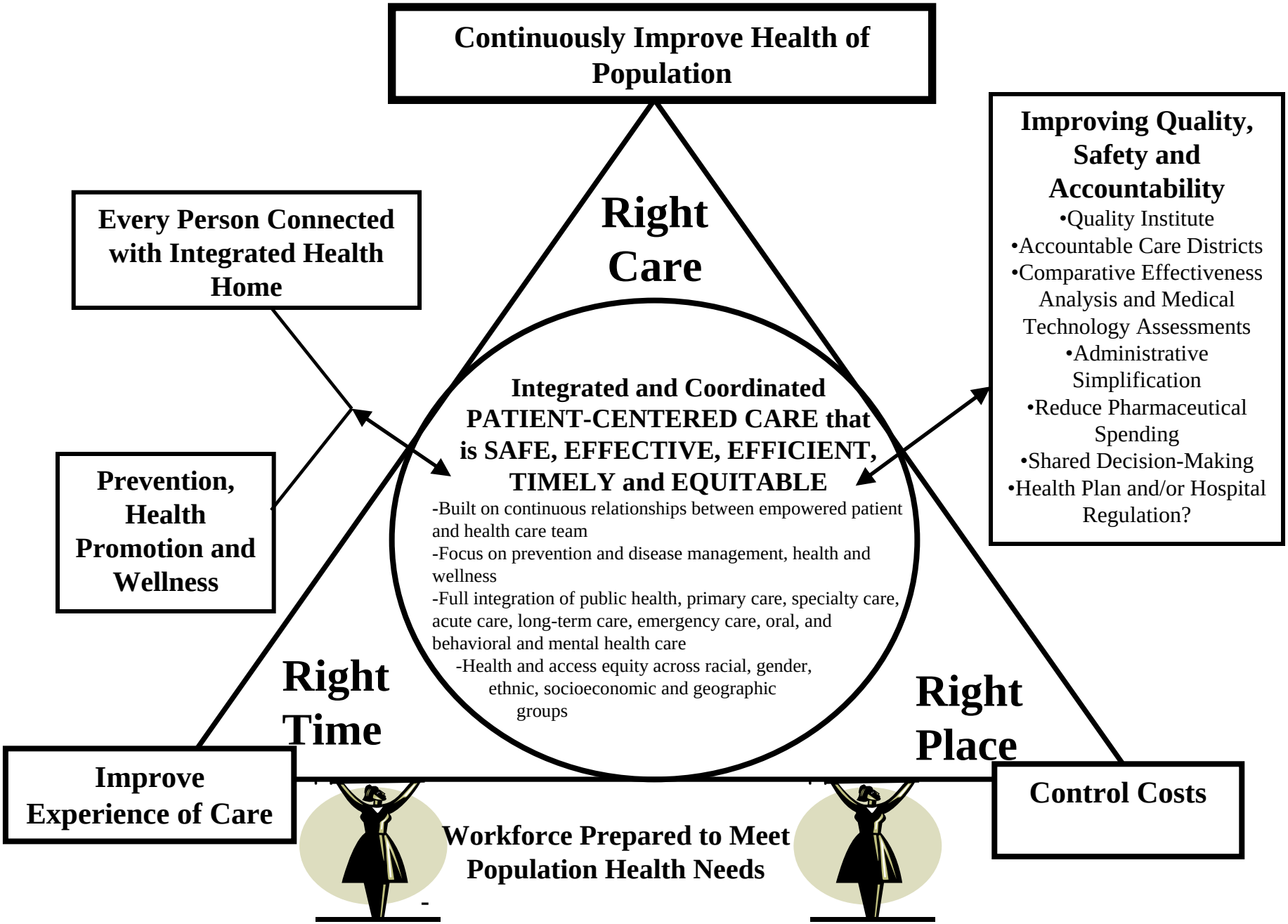
Oregon Health Fund Board Delivery Systems Committee
Cost Containment Strategies
DRAFT FOR DISCUSSION ONLY - REVISED 3/10/08

Goal: Improve Quality and Efficiency of Care Provided Across Oregon

Strategy	Possible Approaches	Target	One-Time or Long-Term Savings
Paying for Quality	Competitive contracting/value-based purchasing for publicly and privately purchased healthcare	Purchasers	Long-term
	No billing for National Quality Forum "never events"	Health plans, providers	Long-term
	**Provide incentives to providers who deliver high quality care (must be cost neutral overall to create a differential between top and bottom performers)	Providers	Long-term
Improved Quality and Transparency	Recommendations from Quality Institute Work Group to be received 3/08 on how to make appropriate cost and quality data easily accessible to multiple stakeholder groups		
Health Information Technology	Recommendations from HIIAC on how to promote widespread adoption of interoperable electronic health records and other health information technologies to support health care decision-making		

**Added after 2/21 meeting

Figure 1: Framework for Delivery System Reform in Oregon
DRAFT 3/18/08



DRAFT "Strawperson" Cost Containment Recommendations
Improving Quality, Efficiency and Accountability
Oregon Health Fund Delivery Systems Committee
DRAFT - 3/31/2008

Accountable Care Districts

Accountable care districts (ACD) could be a way to foster local accountability for quality and the utilization of health resources. Accountable care districts are regional health care delivery systems, comprised of integrated health homes, hospitals, specialists and community-based and social service organizations, which are large enough to support comprehensive performance measurement and can provide or effectively manage the full continuum of patient care. In order to be effective, accountable care districts must involve the communities they serve in decision-making processes.

ACDs could create a framework for cost containment strategies that improve quality and efficiency and increase accountability by:

- Allowing for meaningful aggregation and local accountability of quality and utilization data that provides opportunities to compare resources use among different sites, measure total spending per beneficiary and promote coordination between physicians, hospitals and clinics;
- Promoting collaborative health resource planning based on community-level data, needs and preferences; and
- Facilitating more targeted capitol investment that reduces duplicative services and encourages investment in primary care and other services that improve overall population health.

ACDs can also create a framework in which new reimbursement models that encourage high-quality, efficient care could be developed.

Recommendation 1: Health care quality data reported by the Oregon Quality Institute should be aggregated to allow for meaningful comparisons of quality and utilization data across the state and across ACDs.

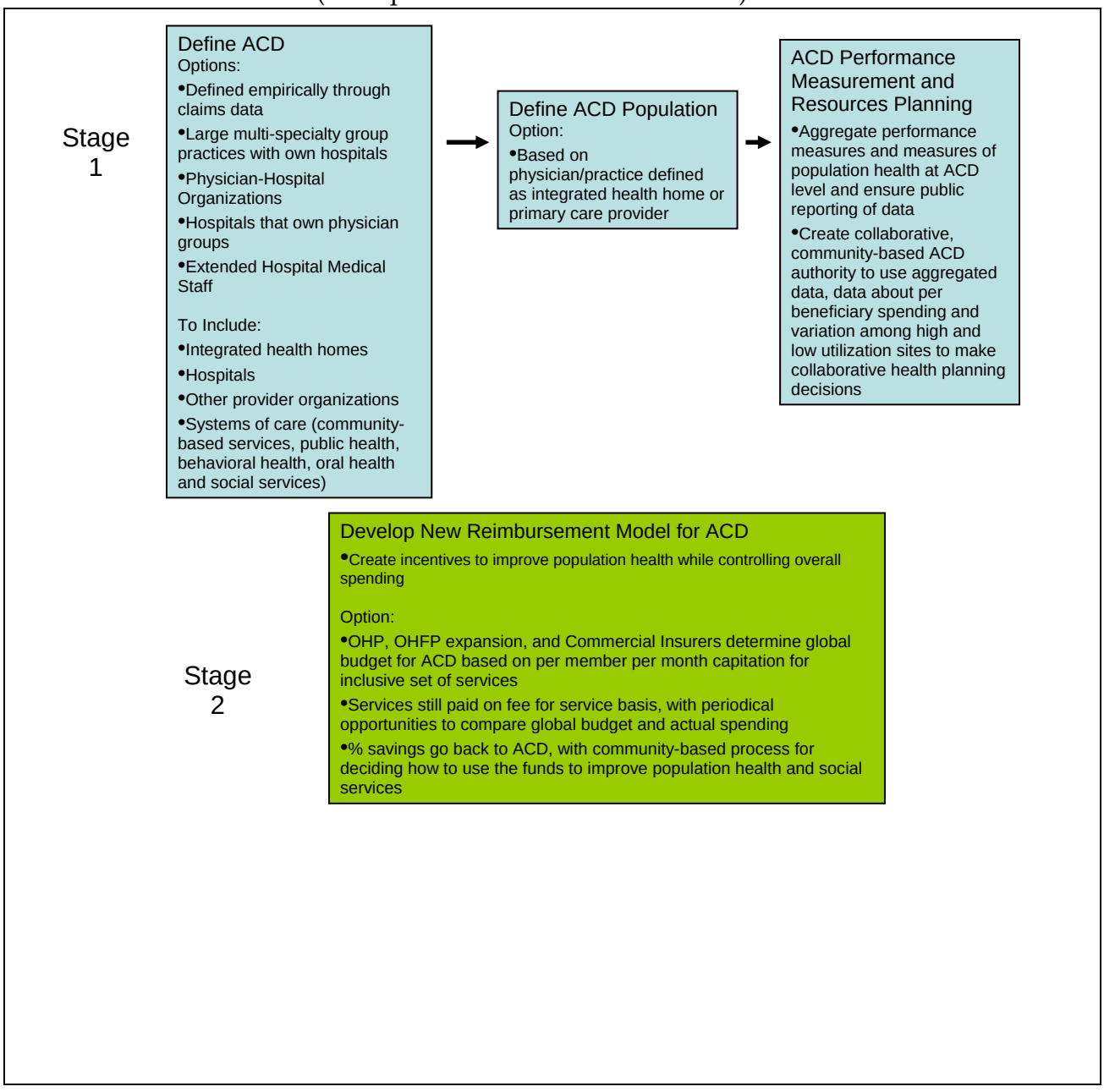
Options for identifying accountable care districts:

- Defined empirically through claims data
- Large multi-specialty group practices with own hospitals
- Physician-Hospital Organizations
- Hospitals that own physician groups
- Extended Hospital Medical Staff (virtual or multi-specialty group practice directly or indirectly affiliated with a single hospital)

Recommendation 2: Accountable care district pilot projects should be funded by the state to establish collaborative, community-based ACD authorities in a few communities across the state. These ACD authorities should use aggregated data to make collaborative health planning and resource utilization decisions and serve as a framework to pilot new reimbursement models, such as care coordination fees and global budgets. Preference should be given to communities that have already demonstrated willingness and ability to create collaborative relationships between stakeholders and use data to drive change.

Accountable Care District (ACD) Pilot Projects

(to be piloted in a few communities)



Comparative Effectiveness Analysis and Medical Technology Assessments

Recommendation 1: Funding for the Oregon Health Resources Commission (HRC) should be increased to allow the group to produce a greater number of evidence-based evaluations of devises, drugs, procedures and other treatments to be widely distributed to stakeholder groups. Opportunities to partner with Washington State to develop a regional comparative effectiveness collaborative should be explored.

Recommendation 2: The benefit package for state funded health programs (OHP, OHFP, PEBB, OEBB) should be designed to cover new technologies and treatments only if evidence proves the new technologies or treatments have added value over those already covered. Technologies and treatments already covered in these programs should be removed from the benefit package if they are found to be ineffective. The state should partner with private purchasers and health plans should collaborate to develop joint policies regarding coverage of new technologies and procedures.

Recommendation 3: The role of the Health Resources Commission (in partnership with the Quality Institute) should be expanded to develop and/or endorse standard sets of clinical guidelines, focusing first on the most prevalent chronic diseases. Incentives should be made available to providers serving Oregonians insured by state funded health programs (OHP, OHFP, PEBB, OEBB) to encourage the use of clinical guidelines when they apply. The state should partner with private purchasers and health plans to develop joint policies regarding standard sets of clinical guidelines.

Administrative Simplification

Recommendation 1: The state should convene a task force, representing public and private payers, hospitals, health care providers and state agencies to work on administrative simplification and standardization issues. The task force should:

- Develop a standard definition of "administrative costs"
- Develop requirements for health plans to be transparent about the % of premiums used for administrative costs
- Develop standards formats and rules for eligibility, claims, and payment and remittance transactions. By 2010(?), all providers and purchasers should be required to use standard formats and electronic exchange for these transactions (modeled after Minnesota Administrative Simplification Act)

Reduce Pharmaceutical Spending

Recommendation 1: All state health programs should purchase pharmaceuticals for enrollees through the Oregon Prescription Drug Program (OPDP) and the

Northwest Prescription Drug Consortium. Medicaid managed care plans should be required to use OPDP unless they can show greater cost savings for their enrollees through other purchasing contracts.

Recommendation 2: The state should develop a single formulary for all state health programs. Private health plans should be encouraged to utilize the state formulary.

Shared Decision-Making

Recommendation 1: The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should develop or endorse standard sets of decision-making support models for integrated health homes and other provider settings. The support model should include protocols for identifying the use of a patient-directed decision-making process and incorporating effectively the use of patient-decision aids, when appropriate. The task force should first focus on developing protocols for conditions involving expensive, invasive and discretionary surgical procedures for which clinical trials have demonstrated the effectiveness of patient decision aids in improving the quality of clinical decision making.

Recommendation 2: All state health programs should require providers to utilize the decision-making support model in treatment of state health program enrollees. Private purchasers and health plans should be encouraged to adopt the decision-making model.

Recommendation 3: The state should seek opportunities to partner with private stakeholders to develop and offer training courses for providers to develop skills in facilitating shared-decision making processes, including the effective use of patient decision aids.

Recommendation 4: Legislation should be passed (modeled after Washington State ESSB 5930) which provides a higher standard of immunity for providers who use patient decision aids from litigation based on failure to provide informed consent.???

Hospital and/or health plan regulation

Options:

- Cap administrative costs and profit/net income of insurance providers
- Limit percent of profit/net income of hospitals with due regard for capital investment needs
- New/more explicit requirements around hospital profit and investment in community in return for tax-exempt status
- Set minimum loss ratios

Summary of Comparative Effectiveness/Medical Technology Assessment Initiatives
Oregon Health Fund Board Delivery Systems Committee
DRAFT FOR DISCUSSION – 3/31/08

Initiatives in Oregon

- The Health Resources Commission (HRC) was created as part of the Oregon Health Plan to encourage the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness an cost of medical technologies and their impact on the health and health care of Oregonians. HRC is directed to conduct medical technology assessments program (MedTAP); serve as a statewide clearinghouse for medical technology information; monitor the use, costs and outcomes associated with selected medical technologies in Oregon, using available data; identify information which is needed but lacking for informed decision making regarding medical technology, and fostering mechanisms to address such deficiencies; provide a public forum for discussion and development of consensus regarding significant emerging issues related to medical technology; and inform health care decision makers, including consumers, of its findings and recommendations regarding trends, developments and issues related to medical technology.
- Oregon's Health Services Commission (HSC) is responsible for developing and maintaining the Prioritized List, which ranks health services based on the comparative benefits of each service to the entire population served. The Commission is directed to encourage effective and efficient medical evaluation and treatment by considering both the clinical effectiveness and cost-effectiveness of health services in determining their relative importance. The Health Services Commission reported a new Prioritized List of Health Services for the 2007-09 biennium, which places a new emphasis on preventive care and chronic disease and also reflects a better account of clinical effectiveness and cost-effectiveness into the ranking of health services. The list is used to determine the services that are covered by the Oregon Health Plan.
- The Drug Effectiveness Review Project (DERP) is a collaboration of organizations that have joined together to obtain the best available evidence on effectiveness and safety comparisons between drugs in the same class, and to apply the information to public policy and decision making in local settings. DERP is funded by the Agency for Healthcare Research and Quality, along with participating organization and is based at Oregon's Center for Evidence-Based Policy at OHSU. The Oregon Evidence-Based Practice Center, also at OHSU, is a participating member in DERP, as are organizations from Arkansas, Idaho, Kansas, Michigan, Minnesota, Missouri, Montana, North Carolina, New York, Washington, Wisconsin and Wyoming and the Canadian Agency for Drugs and Technologies in Health.

National Initiatives and Proposals

- The VA's Technology Assessment Program (VATAP) is a national program within the Office of Patient Care Services dedicated to advancing evidence-based decision making in the VA (including the US Department of Veterans Affairs, Veterans Health Administration and the Office of Patient Care Services). VATAP carries out

systematic reviews of the medical literature on "what works" in health care, promotes excellent health care value through evidence-based decision making, and provides impartial, peer reviewed evidence-based reports to support better resource management in VHA.[i]

- The Technology Evaluation Center (TEC) of the Blue Cross/Blue Shield Association uses scientific criteria for assessing medical technologies through comprehensive reviews of clinical evidence. TEC completes 20-25 assessments a year, which are comprehensive evaluations of the clinical effectiveness and appropriateness of a given medical procedure, device or drug. TEC serves a wide range of clients in both the private and public sectors, including Kaiser Permanente and the Centers for Medicare and Medicaid Services (CMS).[ii]
- The technology assessment program at the Agency for Healthcare Research and Quality (AHRQ) provides technology assessments for the Centers for Medicare & Medicaid Services (CMS). These technology assessments are used by CMS to inform its national coverage decisions for the Medicare program as well as provide information to Medicare carriers. AHRQ's technology assessment program uses state-of-the-art methodologies for assessing the clinical utility of medical interventions. Technology assessments are based on a systematic review of the literature, along with appropriate qualitative and quantitative methods of synthesizing data from multiple studies. AHRQ also contracts with state-based evidence-based practice centers to conduct other evidence-based reports and technology assessments.
- The Commonwealth Fund recommends the establishment of a Center for Medical Effectiveness and Health Care Decision-Making as a public/private partnership to identify information required make better medical decisions, collect information where it exists and generate the information where it does not (Bending the Curve Recommendation 1). The responsibilities of the Center would include providing targeted funding for research intended to evaluate existing and new devices, drugs, procedures and other treatment regimens that it identified as most important for improving overall appropriateness of health care and health care spending.[iii]

Other State Initiatives and Proposals

- The State of Washington's Health Technology Assessment Program was created in 2006 to ensure that health technologies purchased by the state are safe and effective and coverage decisions made by various state agencies are consistent, transparent and based on evidence.[iv]
- The Minnesota Health Care Transformation Task Force recommended the development of a collaborative, non-regulatory body to review new technologies, services, and medications and to recommend whether new services should covered by health insurance plans based on a method similar to the one utilized by Britain's National Institute for Health and Clinical Excellence (Recommendation IV-D).[v]

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[i] Department of Veterans Affairs website. http://www.va.gov/VATAP/
[ii] Technology Evaluation Center website. http://www.bcbs.com/betterknowledge/tec/what-is-tec.html
[iii] C. Schoen, et al. 2007.
[iv] Washginton Health Care Authority website. http://www.hca.wa.gov/shtap/
[v] Health Care Transformation Task Force: Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. 2008.

Background Information

Minnesota Department of Health June 21, 2007

New State Law Requires Electronic Exchange of Administrative Health Care Transactions

- **All health care providers and group purchasers must exchange health care administrative transactions in standard electronic format starting in 2009**
- **Work is now underway to develop rules for the transaction standards by 2008, effective in 2009**

Frequently Asked Questions

What is the new law, and what does it do?

The new law was signed by Governor Pawlenty on May 25, 2007 as part of the state's Omnibus Health and Human Services funding bill (Minnesota Session Laws 2007 - Chapter 147). It adds a new section to the Minnesota Health Care Administrative Simplification Act, Minnesota Statutes, section 62J.536, entitled *"Uniform Electronic Transactions and Implementation Guide Standards."*

Minnesota Statutes, section 62J.536 requires that beginning in 2009:

- All group purchasers and health care providers must electronically exchange the following three health care transactions: eligibility; claims; payment and remittance advice.
- The electronic transactions must be in a standard format, which will be adopted through a rule-making process by the Commissioner of the Minnesota Department of Health, in consultation with the Administrative Uniformity Committee.

Who is affected by the law?

The law applies to "all group purchasers and health care providers" and affects virtually anyone who bills for health care services or purchases health care services on behalf of an identified group of persons.

What is a "group purchaser"?

A "group purchaser" is a person or organization that purchases health care services on behalf of an identified group of persons. It includes, but is not limited to: health insurance companies; health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota Comprehensive Health Association; group health coverage offered by fraternal organizations; professional associations or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

What is a "health care provider"?

"Health care provider" means a person or organization that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under Minnesota Statutes Chapter 256B. The new law

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New State Law Requires Electronic Exchange of Administrative Health Care Transactions

also applies to licensed nursing homes, licensed board care homes, and licensed home care providers. Other examples of providers affected by the new law include (but are not limited to): doctors; hospitals; pharmacists; dentists; chiropractors; personal care attendants; home and community-based service (waivers) providers; and others.

Why was the law enacted?

In health care, as in other industries, administrative costs are reduced and productivity increased when transactions are processed electronically using common formats and conventions. Minnesota's health care industry and other previous state regulations have helped make Minnesota a leader in efforts to reduce health care administrative costs. At the national level, federal rules (known as HIPAA), as well as other industry and state efforts, have also helped bring about much greater use of efficient, effective, standard electronic transactions in health care.

Despite these advances, the health care industry still lags behind other sectors in its use of information technology and common data standards. The new law will accelerate the use of standard, electronic transactions to help reduce health care administrative costs and related "hassle factor." More of every health care dollar can then be spent on maintaining and improving health, and less on duplicative or unnecessary administration.

The new law was a Governor's health care reform initiative. It passed with strong bipartisan legislative support and industry leadership and backing.

How will the new health care transactions rules be developed?

The new health care transactions rules will be developed by the Commissioner of Health, in consultation with the Minnesota Administrative Uniformity Committee (AUC), a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The AUC has served since 1992 to develop agreement among Minnesota payers and providers on standardized administrative processes. The standards for the rules will be based on the Medicare program, with modifications the Commissioner deems appropriate after consulting with the AUC.

The AUC has formed Technical Advisory Groups (TAGs) to reconcile diverse coding and conventions for health care transactions. Planning and initial work with the AUC and the appropriate TAGs is underway to develop the rules required by the new law by 2008, effective in 2009.

What are the compliance dates for the new law?

The rules for Uniform Electronic Transactions and Implementation Guide Standards must be developed at least one year prior to their effective dates. The table below shows the statutory timelines for rule development as well as the effective dates for the rules:

Type of health care transaction	Deadline for Rule Promulgation	Effective Date of Rules
Eligibility	January 15, 2008	January 15, 2009
Claims	July 15, 2008	July 15, 2009
Remit/Payment	December 1, 2008	December 1, 2009

How can I find out more? How can I participate in the consultation process for the Uniform Electronic Transactions and Implementation Guide Standards?

To learn more about the new law, its implementation, and the AUC consultation process, call Kelly Moch at 651-201-3578.

You can also learn more about the AUC and subscribe to AUC updates by going to: http://www.health.state.mn.us/auc/

DRAFT "Strawperson" Payment Reform Proposals
Oregon Health Fund Delivery Systems Committee
DRAFT - 3/31/2008

	Payment	**Key Questions**
Tier 1 Payment Reform	**Quality and Efficiency Based -** providers meeting specific targets (or who show a significant amount of improvement over time) will be eligible for quality/efficiency-based payments. Payments could be incorporated into existing payment systems in a budget neutral way, most likely as withholds. Quality and efficiency targets for primary care providers should focus on preventative services and treatment of patients with the most prevalent chronic conditions *Step 1: Payment based on process measures* – payments to practices meeting process targets in areas including patient experience, population health and improving the care of high risk patients. *Step 2: Payment based on outcomes measures* – payments to practices exceeding outcomes targets	• Should be coupled with expanded fee-for-service payments (newly recognized codes for telephone and email communication, pharmacist medication management and behavioral health counseling for chronic medical conditions)? • Should be coupled with an increase in base payment rates for primary care providers? • Should hospital payments also be adjusted for quality and efficiency performance? • Should specialists/specialty care payments be adjusted similarly?
Tier 2 Payment Reform	**Care Coordination Payments -** providers assuming greater responsibility for coordinating care for patients, particularly those with chronic conditions, will receive "care management fees" for monitoring and managing care. • The amount of the care management fee should be adjusted for the complexity/risk of the patients served (higher fees for patients with multiple chronic conditions and lower fees for patients that just require preventative care.) • Providers will need to meet specific standards to be eligible to receive the care management fees (tied to integrated health home designation process?) • Providers will have to meet Tier 1 quality and efficiency standards to qualify for care coordination payments.	• Should care coordination payments be tied to integrated health home designation process? If so, should there be tiered payments that align with the tiered designation process? • Could care coordination payments be made to accountable care districts, in addition or instead of to individual providers/practices? Could care coordination payments be part of accountable care district pilots? • Since care management fees will create additional payments to providers, is there a way to evaluate whether better coordination leads to a decrease in the use of acute care services and overall cost savings?

Tier 3 Payment Reform	**Global Budgets -** providers and care systems assume responsibility for the total cost of care for the patients they care for, as well as the quality of the care they provide. • Providers and care systems will submit bids to health insurance plans, other health care purchasers, or consortiums of plans and purchasers, on the total cost to provide care for a population with a standard complexity/risk profile. • Budgets must decrease cost over current level of spending. • Payments to providers should still be complexity/risk-adjusted to avoid penalizing patients who care for less healthy and vulnerable populations. • Providers will be required to meet Tier 1 quality and efficiency targets to participate in Tier 3 and quality and efficiency performance payments will still be available to providers operating on global budgets.	• Should global budgets be based on the cost of providing just the "essential benefits package" or all care? • Should global budget bids be publicly reported? • Should amount consumers pay for their health insurance (premium and/or out of pocket) be dependent on the global budget of provider they choose (lower for higher value provider)? • Could global budgets be tested through accountable care district pilots?

Healthcare Payment Reform & Provider Reimbursement: A Summary of Strategies for Consideration by the Oregon Health Fund Board

DRAFT - March 2008

Oregon for Oregon Health Policy and Research

Healthcare Payment Reform & Provider Reimbursement: A Summary of Strategies for Consideration by the Oregon Health Fund Program

Prepared by:

Nicole Janeba

Received by:

The Office for Oregon Health Policy and Research

If you have any questions, or if you need this material in an alternate format, please call (503) 378-2422

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Contents

Executive Summary

The Oregon Health Fund Board (OHFB), as established by the Healthy Oregon Act, is commissioned with developing a healthcare reform plan, which will establish an equitable, sustainable system that provides high-quality, efficient care to all Oregonians. Moreover, it calls for increased care coordination through the use of medical homes. A large piece of this reform is devising a payment structure that promotes the goals delineated by the Act as well as those outlined in the Medical Home Model.

The current approach to provider reimbursement is based on a fee-for-service system that promotes patient over-treatment and lacks incentive for providers to more efficiently coordinate a patient's care. Furthermore, it does little to promote quality care improvements. Without reform, this structure will continue to perpetuate the growth of healthcare expenditures without necessarily improving the population's health. However, creation of a system that rewards providers for rendering quality care in an efficient manner has the potential to cap the costs of healthcare while also leading to improved health outcomes.

Many factors such as cost of care, differences in patient populations, and severity of illness must be taken into account when constructing a payment system. It is also imperative to consider the risk that is assumed by both patients and providers dependent upon method of reimbursement. The level of risk that is assumed by the provider can serve as the basis for encouraging more efficient provision of care. Bearing these factors in mind, the OHFB could consider developing a system that:

1. ***Rewards providers for health outcomes and improvement in quality of care.***
2. ***Adequately compensates providers for care coordination and management services.***
3. ***Is transparent to payers and providers.***
4. ***Is sustainable.***
5. ***Adjusts for risk based on incidence of illness within a given population.***
6. ***Builds on the experiences of other reforms at the local, state, and national level as well as the private sector.***

Introduction

Enrolled Senate Bill 329, the Healthy Oregon Act, established the Oregon Health Fund Board (OHFB) in June 2007.[1] OHFB is charged with developing a comprehensive reform plan for the Oregon Health Fund program. The overarching goals of this reform are to provide all Oregonians with timely access to high-quality, efficient healthcare while also containing costs and ensuring sustainability of the system. In attempt to achieve these goals and provide Oregon Health Fund Program participants with effective, efficient, coordinated care, the act also specifies that the program should support the use of medical homes.

A primary care medical home is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family. The guiding principles of a medical home as developed by the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association focus on the use of a personal physician, a physician-directed medical practice, whole-person orientation, coordinated/integrated care, quality and safety, enhanced access, and an appropriate payment structure.[2]

Restructuring provider[3] reimbursement methods in order to create an appropriate and equitable payment system is, and will continue to be, at the forefront of healthcare reform both at the state and national level. The purpose of this paper is to provide background information about provider reimbursement methods to the OHFB. It looks at factors contributing to the costs of care, payment methods traditionally used within the healthcare system, and suggested payment methods that support the principles of the medical home model.

Reimbursement within the current healthcare system

The current healthcare delivery system relies heavily on a fee-for-service (FFS) payment method in which a provider is paid a fee for rendering a specific service. Although seemingly straightforward, this system is built such that medical overutilization and resource inefficiency are rewarded.[4] Policies which further exacerbate this trend include the undervaluation of preventive services as well as the overvaluation of non-preventive services; non-payment to physicians for services required to provide patient-focused, care coordination; and the provision of incentives for volume of services without regard to quality of care or resource utilization.[5]

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[1] Enrolled Senate Bill 329, The Healthy Oregon Act. June 2007.
[2] Rogers, JC. Strengthen the Core and Stimulate Progress: Assembling Patient-Centered Medical Homes. Family Medicine. 2007; 39(7): 465-8.
[3] In this context, the term "provider" refers to the organization or individual providing healthcare services. For example, a "provider" could be a hospital, diagnostic testing facility, physician, nurse, etc.
[4] Schoen C, et al. Bending the Curve: Options for Achieving Savings and Improving Value in U.S. Health Spending. The Commonwealth Fund. December 2007.
[5] American College of Physicians. Reform of the Dysfunctional Healthcare Payment and Delivery System. 2006. Available: http://www.acponline.org/advocacy/where_we_stand/policy/dysfunctional_payment.pdf.

There are concerns that without a radical shift in provider reimbursement methodology, the current system is unsustainable and could lead to the collapse of primary care.[6]

Types of payment methods – There are six methods of provider reimbursement, which have been traditionally utilized within the healthcare system:[7]

- **Fee-for-service**: A provider is paid a fee for rendering a specific service.
- **Per diem**: A provider is paid a set amount per patient for each day that patient is in the provider's care. All services rendered during that day are covered under the set amount.
- **Episode-of-care**: A single provider is paid a set amount for all services rendered (by that provider) during a defined "episode" of care. For example, a provider may be paid a pre-determined amount for a patient undergoing a kidney transplant. This payment would cover the surgery and all services, including follow-up, associated with that "episode." Using this method there would typically be multiple payments for a single episode since more than one provider may treat a patient.
- **Multi-provider bundled episode-of-care**: Multiple providers are jointly paid for all services rendered during an episode of care, as defined above. Using this method there would only be a single payment made by the payer[8], which would cover the services rendered by all providers.
- **Condition-specific capitation**: One or more providers are paid a pre-determined fee to cover all services rendered for a specific condition. These payments can be either a one-time fee or on going depending on the severity of the illness.
- **Capitation**: One or more providers are paid a regular, pre-determined fee to cover all services rendered for the continuous care of a patient. This fee covers all episodes and all conditions.

Currently, the majority of providers are reimbursed using either a FFS, per diem, or episode-of-care payment with FFS being the most predominantly used. Capitation is still utilized as a method of payment, although not as often as it was in the 1990s during the height of managed care organizations.[9] Medicare uses both FFS methods and an episode-of-care method called a prospective payment system (PPS).[10] The PPS uses diagnosis-related groups (DRG) to classify services, which can be bundled together into a single payment for an "episode." This method of payment may reduce the risk assumed by providers; however, it is also believed that DRG payment systems are too slow to incorporate new medical technology.[11]

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[6] Shodell D. Public Health Perspective: Paying for Prevention. Medscape Public Health & Prevention. 2006; 4(2). Available: http://www.medscape.com/viewarticle/544651.

[7] Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

[8] In this context, the term "payer" refers to the organization, such as an employer or health insurance plan, or individual purchasing healthcare services.

[9] Ibid.

[10] Centers for Medicare and Medicaid Services. Prospective Payment Systems – General Information. Available: http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/.

[11] Nichols LM, O'Malley AS. Hospital Payment Systems: Will Payers Like the Future Better Than The Past? Health Affairs. 2006; 25(1): 81-93.

The Medicare FFS rates are determined by relative value units (RVU) using the resource-based relative value scale (RBRVS). Each piece of providing a service, including physician work, practice expense, and professional liability insurance, is translated into a RVU. Physician reimbursement is calculated by totaling the RVUs for all services rendered. Adjustments are made for geographical location.[12]

The Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) have recently endorsed expansion of Medicare's partially bundled PPS for certain services. There are nine key elements that were considered in the design of Medicare's bundled PPS[13]:

- A specific scope of services included in a bundled rate that has a defined unit of payment;
- Case-mix adjustments[14] that reflect the variation of resources for individual patients;
- Geographic adjustments that reflect variation in costs by geographic region;
- Adjustments based on facility characteristics such as size;
- Design or implementation issues unique to a particular service such as separation or consolidation of rates for multiple facilities;
- Operational, administrative, and systems issues dependent upon the magnitude of change required to adopt a bundled PPS;
- Requisite provider education;
- Establishment of initial payment rates and a process for payment rate updates;
- Encouragement of providers to more efficiently render service.

The last element, encouraging providers to render services more efficiently, has raised the concern that some providers may actually limit services that are medically needed. However, among Medicare beneficiaries, a relationship between higher expenditures/higher utilization of services and higher quality of care/better health outcomes has never been established.[15]

The cost of care – There are several variables that contribute to the overall cost of a patient's care (Figure 1). Inevitably, if any of these variables increase, the overall cost of care increases. In regard to the actual payment for a patient's care, these variables embed themselves within one of six "cost types": primary care physician services, specialist physician services, diagnostic services, drugs and medical devices, short-term non-physician services and facilities, and long-term non-physician services and facilities.[16] The framework under which a payment system is

[12] American Medical Association. The Resource-Based Relative Value Scale. Available: http://www.ama-assn.org/ama/pub/category/16391.html.
[13] Leavitt MO. A Design for a Bundled End Stage Renal Disease Prospective Payment System. US Department of Health and Human Services. 2008. Available: http://www.cms.hhs.gov/ESRDGeneralInformation/downloads/ESRDReportToCongress.pdf.
[14] Case-mix adjusting is the process of grouping patients according to expenditure and resource utilization.
[15] Schoen C, op. cit.
[16] Miller HD, op. cit.

designed depends on whether these costs are paid for separately or whether one fee covers multiple services in a bundle as described in the previous section.

Figure 1. Variables Contributing to the Cost of Care

$$\frac{\text{Cost}}{\text{Patient}} = \frac{\text{Cost}}{\text{Process}} \times \frac{\text{No. of processes}}{\text{Service}} \times \frac{\text{No. of services}}{\text{Episode of care}} \times \frac{\text{No. of episodes of care}}{\text{Condition}} \times \frac{\text{No. of conditions}}{\text{Patient}}$$

Source: Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

When constructing a payment system, it is important to note that not all costs are necessarily incurred during the same timeframe. One typically considers the cost of care to be those charges that are incurred at the time of service. This portion of the overall cost of care is referred to as short-run direct costs. However, one must also consider short-run indirect costs, the cost of lost productivity during recovery; long-run direct costs, future provider expenditures that are attributed to current care (or lack thereof); and long-run indirect costs, the cost of lost productivity in the future as a result of current care (or lack thereof). The total cost can be tabulated as the sum of each of these[17]:

Total cost = Short-run direct costs +
Short-run indirect costs +
Present value[18] of long-run direct costs +
Present value of long-run indirect costs

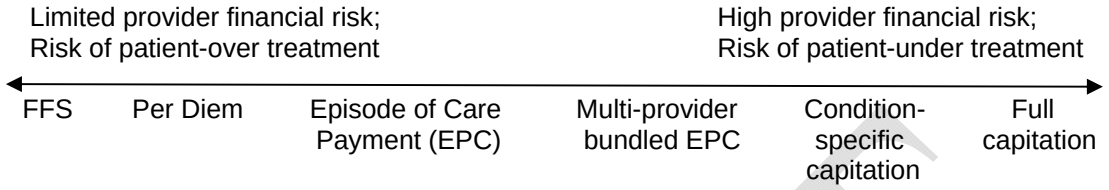
For example, a provider overlooks giving a patient a pnemonia vaccine during an exam. As a result, the patient contracts measles at some point in the future. The total cost of care that can be associated with the initial exam visit is the cost for services provided at the visit plus the cost of all services relating to the measles treatment plus the cost of lost productivity (i.e. time off of work, etc.) during the patient's recovery from measles. Under a FFS system, total expenditures will be greater for the payer since he is responsible for reimbursing the long-run direct costs. In this instance, the long-run direct cost is the cost of service for measles treatment. However, in a system that uses capitation for reimbursement, the provider assumes responsibility for the total care of the patient, which would include treatment for measles. This care would be provided without any additional reimbursement by the payer. The value of considering long-run costs becomes increasingly apparent when tabulating the cost of care for preventive services. The long-run costs associated with a lack of available preventive services outweigh the short-run direct costs of providing many of those services.

Reimbursement and risk – Each type of provider reimbursement method carries its own set of risks. Those risks are assumed either by the payer, the provider, or both. Generally speaking, as

[17] Ibid.
[18] The present value of a long-run cost takes into account future price inflation for a service.

you move down the payment type list from FFS to capitation, the risk shifts from payer to provider (Figure 2).

Figure 2. Continuum of Health Care Payment Methods



Source: Miller HD. Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund. September 2007.

FFS systems, as mentioned previously, tend to provide financial incentives for providers to over-treat the patient. Here, the payer must assume the full risk of care. He can pay, or choose not to pay, for as many services as the provider is willing to render. Episode-of-care payments put slightly more risk on the provider since it is unknown at the beginning of the "episode" exactly what services may be needed. Condition-specific capitation creates incentives for the provider to limit the number of "episodes" of care per condition.[19] Full capitation creates incentives for providers to prevent illness in the patient and to treat any illness in an efficient manner. However, this also puts providers at risk if they treat populations that are sicker than average. Essentially, payment methods that include any kind of bundling or capitation create a financial risk for providers, which may cause them to under-treat their patients. Payment methods that individualize services and their associated payments (i.e. FFS) create a risk of providers over-treating their patients.[20] Table 1 presents each reimbursement method with the trigger for payment and associated risks. Here, episode-of-care and multi-provider bundled episode of care payment are combined into the category of "case rate" and condition-specific capitation and full capitation are combined into simply "capitation."

Table 1. Unit of Payment and Financial Risk in Medicare

Unit of payment	Trigger for payment	Selection risk	Utilization risk
FFS	Delivery of service	Almost none; sicker patients lead to greater volume or more intense service mix, or both	Providers try to have their cost (intensity per unit) below other providers' costs
Case rate	Onset of treatment for diagnosed patient	Average severity within the definition of a qualified case	Providers must control the volume and intensity of each case
Capitation	Enrollment or assignment to panel	Areawide incidence rates, plus average severity, for all types of conditions	Providers must control the volume and intensity of each member

Source: Wallack SS, Tompkins CP. Realigning Incentives in Fee-For-Service Medicare. Health Affairs. 2003; 22(4): 59-70.

[19] Miller HD, op. cit.
[20] Ibid.

Patient/Condition differential and reimbursement – Within a given payment system, it may be necessary to include a few different kinds of reimbursement methods based on patient or condition type. Four distinct categories of condition type should be considered when defining a payment system[21]:

- **Major Acute Episodes**: A patient typically requires several, often expensive, services within a short period of time (i.e. heart attack, stroke, major trauma, etc.).
- **Chronic Conditions**: This includes care associated with the chronic condition but not care associated with exacerbation of the condition that may lead to more serious treatment. For example, regular check-ups and medication for an asthma patient would be included in this category. However, a hospitalization resulting from failure to properly use an inhaler for the asthma would not be included.
- **Minor Acute Episodes**: A patient may have a self-limiting condition or a condition not requiring treatment. This category also includes conditions that could lead to more serious illness if left untreated (i.e. minor wounds, minor respiratory illness, etc.).
- **Preventive Care**: This includes services that are provided to prevent both chronic conditions and acute episodes (i.e. immunizations, counseling, etc.).

Our broken payment system – As eluded to previously, there are several problems that our current healthcare reimbursement system facilitates. First and foremost, our payment system does not encourage providers to consider the appropriateness of the services they render. FFS systems often reward providers for rendering unnecessary or low-value services while also offering disincentive to focus on preventive or palliative care. Essentially, providers are not adequately compensated for spending time with a patient whether it is to explore patient history, symptoms of illness, or chronic disease prevention. They are, however, overcompensated for ordering additional diagnostic tests, treatments, medications, and so on. Re-aligning the priorities of our healthcare system with provider incentives to include quality and efficiency in health services would result in a higher level of illness prevention, more accurate diagnoses/prognoses of conditions, more appropriate care, avoidance of adverse events, and improvements in follow-up to care.[22]

The future of the healthcare payment system

"Absolute simplicity is impossible, but relative simplicity – reducing the number of prices to negotiate – is imaginable."[23]

In order to promote a value-based, patient-centered healthcare system, provider reimbursement models should[24,25,26,27]:

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[21] Ibid.
[22] Ibid.
[23] Nichols, op. cit.
[24] Miller HD, op. cit.
[25] Patient Centered Primary Care Collaborative. A New Physician Payment System to Support Higher Quality, Lower Cost Care Through a Patient-Centered Medical Home. May 2007. Available: http://www.pcpcc.net/content/physician-payment-reform.

- Encourage providers to deliver care in a high-quality, efficient manner;
- Ensure the accurate valuation of provider services including care coordination and management work that is conducted outside of face-to-face patient visits;
- Support and encourage investment in health information technologies that will lead to improvements in efficiency and quality;
- Support coordination of care among multiple providers;
- Provide accountability and transparency.
- Not encourage or reward over-treatment or medically unnecessary procedures;
- Not encourage or reward under-treatment or exclusion of high-risk patients;
- Not reward provider errors or adverse events;
- Not encourage cost-shifting.

Although there is a high level of consensus on the attributes that a revised payment model should hold, there has not been widespread adoption of such systems. When constructing a payment system, categories that must be addressed include the basic payment method, possible bundling of services, payment levels, and performance standards[28]. The following section describes payment system proposals that promote the efficient provision of high-quality care. The section entitled 'Pay-for-Performance' explores several options for provider rewards programs that could be combined with provider reimbursement mechanisms.

Uniform provider payment methods and rates – This payment system would require all payers to adopt payment rates and methods similar to those of Medicare. All rates would be publicly available and updated periodically to reflect annual fluctuation in productivity and per-unit costs. It is estimated that implementation of this system would result in national, system-wide savings of $23.1 billion over 5 years[29]. Although there is great potential for savings, implementation of this payment system would possibly result in a reduction in income for some providers. It would most likely effect providers who typically do not see many Medicaid patients and/or those who currently have high reimbursement rates. In order to avoid legal complications surrounding anti-trust laws, legal advice should be sought before establishing uniform payment levels across all payers and providers.

Prometheus Payment Model – The Prometheus payment model is based on evidence-informed case rates (ECR): single, risk-adjusted, prospective payments shared between multiple providers, both in inpatient and outpatient settings, to care for a patient with a particular diagnosis[30]. The payment would be based on the total amount of resources required to provide care for an entire episode. In addition, a portion of the payment would be withheld and re-distributed based on provider performance. The foundation of this model is to separate technical risk from

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[26] American College of Physicians, op. cit.
[27] Rogers JC, op. cit.
[28] Miller HD, op. cit.
[29] Schoen C, op. cit.
[30] de Brantes F, Camillus JA. Evidence-Informed Case Rates: A New Health Care Payment Model. The Commonwealth Fund. April 2007.

probability risk for the provider. Each provider would be held accountable for technical risk through the utilization of payment-linked performance standards but shielded from the probability risk by risk-adjusting the payments.

Although ECRs, also called episode-of-care payments, are gaining popularity, there may be barriers to implementation for some providers. Without a more integrated delivery system, it may be difficult to identify the entity to which the ECR should be paid if more than one provider is involved with the patient's care. Furthermore, identifying the exact onset of an episode for which an ECR may apply could prove to be challenging for some patients and/or conditions.

Primary Care Case Management programs – Physician practices that are certified as medical homes could receive a per-member per-month (PMPM) fee in addition to current FFS rates. The PMPM would cover enhanced primary care services such as care coordination and chronic disease management. Quality and efficiency based incentives could also be used in conjunction with this model. Expansion of programs such as these has the potential to achieve a national, system-wide savings of $193.5 billion over 10 years with $4.1 billion in savings seen at the state level.[31] A shortage of primary care physicians may serve as a barrier to implementation.

Virtual Bundling Payment Program – MedPAC recently presented an option for payment reform that aims to slow the growth of Medicare expenditures. It calls for implementation of a bundled payment system for all services associated with a hospitalization. In this instance, the term "hospitalization" includes the hospital stay plus 30 days following discharge.

The recommendations regarding bundled payments that were proposed by the commission are as follows[32]:

1. Congress should require CMS to confidentially report provider resource use around hospitalizations. After two years, Congress should implement a virtual binding bundling system that would reduce payment to hospitals and inpatient physicians with relatively high resource use for defined conditions. This payment penalty would be used to finance bonus payments to providers with relatively low resource use.
2. Congress should require CMS to create a voluntary pilot program to explore issues related to actual bundled payments for services around a hospitalization.

A virtual bundling system would retain the current fee-for-service (FFS) system but payment to both hospitals and inpatient physician services would be adjusted based upon the amount of services rendered to a patient during a hospitalization. The fee would also be subject to a withhold. High and low benchmark spending levels would be determined prior to implementation. Providers with average or relatively low overall expenditures would be eligible to get the withhold back; however, those with relatively high expenditures would not be reimbursed for the withhold. All Medicare providers would be required to participate in this program.

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[31] Schoen C, op. cit.
[32] Medicare Payment Advisory Commission. Public Meeting. March 5, 2008. Available http://www.medpac.gov/transcripts/03050306Medpac%20final.pdf.

The first draft recommendation was proposed with the rationale that providers might not be aware of the total amount of resources that can be associated with a patient's hospitalization. However, once provided with this information, they may find ways to alter their practice, which could result in more efficient resource coordination. It creates an incentive for both hospitals and physicians to be accountable for spending across a patient's episode. Additionally, this concept could be combined with a pay-for-performance program to hold providers accountable for quality.

The second draft recommendation addresses the issue that not all providers may be prepared to implement an actual bundled payment system. Participation in the 'actual bundled payment' pilot program would be completely voluntary. As opposed to the virtual bundling system, an actual bundling payment system would replace the current FFS system with an episode-of-care payment structure.

Gain sharing – In this context, gain sharing is referred to as the ability for physicians to share savings that result from the efficient use of services and reductions in medical errors. This concept raises the concern that these arrangements could potentially have negative impacts on quality of care. Accordingly, there are several federal restrictions on gain sharing arrangements including federal antikickback statutes and the Stark Laws. However, following a successful CMS demonstration using gain sharing as a means to reduce spending for cardiovascular care, the Office of the Inspector General issued several advisory opinions allowing gain sharing arrangement for specific services at selected hospitals. Furthermore, MedPAC recommended in 2005 that "Congress should grant the authority to allow gain sharing arrangements between physicians and hospitals and to regulate those arrangements to protect the quality of care and minimize financial incentives that could affect physician referrals."[33] Currently, the only way to pursue gain sharing as a method of reimbursement is to participate in a federally sponsored demonstration project.

Primary Care Comprehensive Payment – The current system of encounter-based payments would be replaced with a risk/needs adjusted payment made to primary care providers for comprehensive care of patients. The monthly payment would be sufficient to cover all expenses including salaries that are associated with a physician's group practice (Table 2). It has been suggested that a proportion of such a payment be performance or outcomes based and paid as a bonus for achieving predetermined goals.[34] Under this model, charges from hospitals or specialists would not be covered by the payment and would remain the responsibility of the payer.

[33] Wilensky GR, Wolter N, Fischer MM. Gain Sharing: A Good Concept Getting a Bad Name? Health Affairs, web exclusive. 2007; 26(1): w58-w67.

[34] Goroll AH, Berenson RA, Schoenbaum SC, et. al. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. Journal of General Internal Medicine. 2007; 22(3): 410 – 415.

Table 2: Sample allocation formula for comprehensive payment system*

Formula for comprehensive payment for adult primary care

- 25% - Physician reimbursement: (250K before bonus and fringe) PCP reimbursement (all care)
- 60% - Staff, fringe, rent, office expense (assumes hiring of multidisciplinary office team charged with timely delivery of personalized comprehensive care): (600K)
    - Nurse practitioner: 100K
    - Nurse: 90K
    - 0.5 FTE Nutritionist: 35K
    - 0.5 FTE Social worker: 35K
    - Receptionist: 60K
    - Medical assistant: 50K
    - Rent: 40K
    - Office expenses: 50K
    - Insurance: 50K
    - Physician fringe: 75 – 90K
- 10% - Information technology/patient safety/quality monitoring (100K)
    - Purchase/lease/setup of electronic health record and quality monitoring system: 35K
    - Data manager: 65K
- 5% - Performance bonus for meeting established goals (50K)

*Example assumes an avg. comprehensive payment of $500/yr/pt, an average panel size of 2,000 patients/full time primary care physician and team, 30% fringe benefit, and gross revenue of $1M/full time primary care physician and team.
Source: Goroll AH, Berenson RA, Schoenbaum SC, et. al. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. Journal of General Internal Medicine. 2007; 22(3): 410 – 415.

Pay-for-Performance

Pay-for-performance (P4P) is a method of reimbursing providers based on the achievement of pre-determined measures of quality. Quality can be outcome-based and measured in terms of benchmarking, or quality can be process-based and measured in terms of improvement.[35] Implementation of P4P programs can help to counteract some aspects of our current payment system that do not promote quality improvement.[36] There is a growing interest in these programs due to variation in quality across providers, difficulty within the current payment system to reward high-quality, cost-effective care, and the lack of incentive within the current system to encourage providing services with long-term health or cost savings payoff.[37] It has also been cited that consumer choice alone does not provide sufficient incentive for providers to improve their quality of care.[38] Moreover, it has not been shown that consumers consistently use available information on quality to aid in their healthcare decision-making.

P4P programs can include non-financial as well as financial incentives. Non-financial incentives include but are not limited to performance profiling and referral, public recognition, and technical assistance. Since this report is aimed at provider reimbursement, this section will focus more on financial P4P incentives

[35] Llanos K, Rothstein J, Dyer MB, et. al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.
[36] Schoen C, op. cit.
[37] Nichols LM, op. cit.
[38] Rosenthal MB, Fernandopulle R, Song HR, et. al. Paying For Quality: Providers' Incentives For Quality Improvement. Health Affairs. 2004; 23(2): 127-141.

The most common form of P4P financial incentive is the bonus payment. Bonus payments are monetary sums paid to providers in addition to the usual fee associated with a service if the provider reaches certain quality goals. There are various types of bonus payments as well as a few additional methods of financial incentives used in P4P systems (Table 3).

Table 3. Examples of Financial Incentives Models

Financial Reward	***Example***
Pay-for-participation	The primary care provider (PCP) is reimbursed for time spent at quality improvement workgroup meetings focused on women's health or time spent attending meetings to review performance profiling information and developing quality improvement action plans.
Pay-for-process	The PCP receives an automatic payment of $10 every time one of the PCP's age-appropriate, female, adult patients receives a biannual mammogram.
Quality grant	The PCP may apply for a grant to implement a patient registry system to facilitate tracking of patients in need of a routine mammogram.
Bonus for achievement of a predetermined threshold	The PCP receives a bonus payment if 80 percent or more of age-appropriate, female, adult patients received a mammogram in the past two years.
Tiered bonus for achievement of predetermined thresholds	The PCP receives a bonus payment if 80 percent or more of age-appropriate, female, adult patients received a mammogram in the past two years. The PCP receives a larger payment if more than 90 percent did so.
Tiered bonus based on comparative ranking	The PCP receives a bonus payment if ranked in the top 50 percent of PCPs for delivery of mammograms to age-appropriate, female, adult patients in the past two years. A larger payment is received if ranked in the top 25 percent of PCPs.
Bonus for demonstration of improvement	The PCP receives a bonus payment if the PCP demonstrates a statistically significant increase in the percent of age-appropriate, female, adult patients receiving a mammogram in the past two years. PCPs with rates over 90 percent also receive the bonus since further improvement above 90 percent might be extremely difficult to achieve.
Performance-based fee schedule	The PCP is paid 105 percent of the usual fee schedule if strong performance on several performance metrics distinguishes the PCP from other PCPs.
Compensation at-risk	The PCP forfeits a fee schedule increase unless the PCP achieves the statewide mean on several identified performance metrics.

Source: Llanos K, Rothstein J, Dyer MB, et. al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

It has been shown that hospitals can gain up to 15% in additional revenue from the successful implementation of P4P programs, and it has not been demonstrated that these programs put hospitals at a large financial risk.[39] This may, however, be dependent upon how the program is

[39] Ibid.

designed. Generally speaking, public P4P initiatives tend to be budget neutral while programs in the commercial sector are not. For example, some private payers, such as BCBS of Michigan, make use of the bonus payment without an explicit source of funding such as a withhold.[40] Whereas, the national CMS demonstration project funded payment by reducing the yearly total base payments for all hospitals in the PPS by an amount equal to the total projected bonus payments.[41] States have used additional methods of funding bonus payments including budgeting specific pools of dollars; funding "challenge pools" where unearned bonus monies or unearned withheld capitation payments are paid out to those who excel; reallocating monies collected as penalties; linking rate increases to physicians meeting certain standards; and withholding a portion of an organization's capitation payment and paying it back later contingent upon performance.[42]

The private sector has more experience with P4P programs; however, several pilot projects have taken place at the state level for both Medicaid and Medicare. Preliminary data for a national Medicare P4P demonstration has recently been published. The following section describes selected national, state, and commercial P4P efforts.

CMS/Premier Hospital Quality Incentive Demonstration – The Centers for Medicaid and Medicare Services/Premier Hospital Quality Incentive Demonstration (HQID) project is a collaborative P4P effort consisting of over 250 hospitals around the United States.[43] The explicit goal of this project is to determine if "economic incentives are effective at improving the quality of inpatient care."[44] Between October 2003 and June 2007, hospitals were measured on their attainment of composite quality scores (CQS) for several clinical conditions.[45,46] Bonus payments were paid to each hospital based on one of three types of performance[47]:

- Top performance: Relative to other hospital performance, hospitals that attained or exceeded the 90th percentile CQS for a given clinical area received a 2% bonus on Medicare payments for discharges in that clinical area.
- Absolute performance: Hospitals that attained or exceeded an absolute level of performance in any clinical area independent of other hospital performance received a 1% bonus on Medicare payments for discharges in that clinical area. The absolute level of performance was defined as the 75th percentile among all hospitals during the two years prior to payment.

[40] Ibid.
[41] Schoen C, op. cit.
[42] Llanos K, op. cit.
[43] Premier, Inc. Hospital quality improving, cost, mortality rate trends declining for participants in Medicare Pay-for-Performance Project. January 31, 2008. Available: http://www.premierinc.com/about/news/08-jan/performance-pays-2.jsp.
[44] Lindenauer PK, et al. Public reporting and Pay for Performance in Hospital Quality Improvement. New England Journal of Medicine. 2007; 365(5): 486-491.
[45] Premier, Inc., op. cit.
[46] Schoen C., op. cit.
[47] Ibid.

- Performance improvement: Hospitals that show an improvement in any clinical area as determined by a ratio of the payment year's CQS to the previous two years CQS received a 1% bonus on Medicare payments for discharges in that clinical area.

Bonuses averaged $71,960 per year; however, these payments were partially offset by financial penalties incurred by hospitals with low performance. At the culmination of the demonstration, those hospitals in the lowest two deciles for a given clinical area were penalized 1 – 2% of their Medicare payments for discharges in that clinical area.[48]

The hospitals participating in the P4P program as well as the control hospitals that did not implement a P4P system showed improvement in each of the measured areas of quality. However, hospitals with the P4P program showed significantly greater improvement when compared to the control hospitals in 7 out of 10 individual measures.[49] On average, the median hospital cost per patient in the P4P hospitals declined by over $1,000 during the span of the demonstration, and the median mortality rate decreased by 1.87%.[50]

It is estimated that an expansion of this project to all acute care hospitals that are paid under the Medicare PPS would result in an estimated net savings of $34.0 billion over 10 years. The impact to state and local governments would be a savings of $0.8 billion over 10 years.[51] The estimated savings is predominately due to an expected decrease in readmissions for Medicare beneficiaries. It should be noted that these estimates are only based on P4P programs for inpatient services. If the program was expanded to all providers and all services, additional savings could be achieved.

SoonerCare Choice – SoonerCare Choice is a PCCM in Oklahoma that provides health care for low-income, Medicaid-eligible, pregnant women; children; and the SSI-eligible population. Its P4P program provides bonus payments, averaging approximately $2,800 per provider, to physicians for completing early periodic screening, diagnostic, and treatment requirements for children. Since program implementation in 1997, the state has seen its EPSDT rates improve by over 20%. The state funds its program by designating $1 million per year for bonus payments.[52]

Access Plus – Access Plus is an enhanced primary care case management (PCCM) program in Pennsylvania that is based on a medical-home model of complex case management for children and adults. The state contracts with case management vendors for several different chronic conditions. In addition to providing incentive for achieving improvement in clinical outcomes, the P4P program embedded in this system is structured to provide incentive for physician offices to actively collaborate with the case management vendor. (Table 4).

[48] Lindenauer PK, op. cit.
[49] Ibid.
[50] Premier, Inc., op. cit.
[51] Schoen C., op. cit.
[52] Llanos K, op. cit.

Table 4. Sample P4P Payment Opportunities in Access Plus Program

Metric eligible for payment	Amount	Practice is paid for:	Eligibility
Supports ACCESS Plus program as outlined in the pay for performance program enrollment form including completing the physician survey and communicating support of the program to ACCESS Plus patients	$200	activities outlined in the pay for performance program "Initial Participation Enrollment Form"	PCPs, dentists, OB/GYNs
Provider (or member of practice staff) completes smoking cessation counselor registration with Department of Health	$200	provider/practice registration as a smoking cessation counselor, one time payment	PCPs
Completes and returns Chronic Care Assessment Tool (CCAT) for high risk asthma, CAD, CHF, COPD and diabetes patients	$40	each form completed for eligible patients, as requested, up to twice a year/patient	PCP
Contacts and encourages participation of ACCESS Plus patients listed on mailed "patient roster/action items" document	$40	each patient contacted, as requested, on mailed "patient roster/action items" document	PCPs
ACCESS Plus disease management program patient enrollment support	$30	complete demographic information received for each patient, as requested in mailed "patient roster/action items"	PCP
Electronic submission of a Chronic Care Assessment Tool (CCAT)	$2	each unduplicated eligible patient for whom an electronic CCAT is submitted per year	PCP

Source: PA Access Plus. Pay For Performance Summary of Payment Opportunities. Available: http://www.accessplus.org/downloads/P4P/P4P_SummaryPaymentOpportunities.pdf

Excellus/Rochester Individual Practice Association – The Excellus/Rochester Individual Practice Association (RIPA) Rewarding Results Initiative is a collaboration between a health plan, Excellus, and a physician group, RIPA. Excellus provides shared savings programs that give financial contributions to the RIPA Value of Care plan, a P4P program. RIPA contributes approximately 10% of its total capitation from Excellus to the P4P program. Value of Care then redistributes these funds to RIPA physicians based on performance and shared savings. The average return for a RIPA primary care provider ranges between $4,000 and $12,000 dollars. The Excellus/RIPA program was the first rewarding results initiative, a national grant-awarding program to help purchasers and health plans align incentives for high quality healthcare, to realize a positive return on investment (Table 5).[53]

[53] Ibid.

Table 5. Excellus/RIPA Return On Investment Calculations – Diabetes and Coronary Artery Disease

	2003	2004
Expenses:	$1.15 million	$1.15 million
Savings on trend:	$1.90 million	$5.80 million
ROI:	1.6:1	5.0:1

Source: Llanos K, Rothstein J, Dyer MB, et. al. Pay-for-Performance in Medicaid: A Guide for States. Center for Healthcare Strategies, Inc. March 2007.

Integrated Healthcare Association – The Integrated Healthcare Association (IHA) P4P project is a collaborative that includes 7 California health plans, 225 physician organizations, and over 35,000 physicians. The participating health plans have developed a uniform performance measure set that covers clinical quality, patient satisfaction, and investment in information technology. Since its implementation, the health plans have seen a 40% increase in patient visits and reduced hospitalizations. Furthermore, between 2003 and 2005, the mean medical group performance for breast cancer screening increased by 4%, cervical cancer screening increased by 6.9%, and HbA1c screening for diabetics increased 7.6%.[54]

Bridges To Excellence – Bridges to Excellence (BTE) is an employer-driven P4P program that is targeted toward providers in program eligible specialties that include primary care, endocrinology, cardiology, neurology, orthopedics, and neurosurgery. It is composed of 4 sub-programs[55]:

- Physician Office Link: Rewards physician office sites based on implementation of specific processes intended to reduce errors and increase quality.
- Diabetes Care Link: Rewards providers based on 3-year performance in diabetes care.
- Cardiac Care Link: Rewards providers based on 3-year performance in cardiac care.
- Spine Care Link: Rewards providers based on 3-year performance in spine care.

BTE bonuses are paid directly to physicians, not to the group or practice that achieves the recognition. BTE has a suggested reward structure (Table 6); however, it is up to the individual health plan administering the program to determine the actual reward amounts.[56] In January 2008, BTE launched its medical home program whereby physicians can receive a bonus in addition to other program incentive payments if they can demonstrate that they have adopted systems of care that are consistent with the medical home model.[57]

[54] Ibid.
[55] Bridges to Excellence. BTE Reward Administration Guidelines. 2007. Available: http://www.bridgestoexcellence.org/Documents/BTE%20Reward%20Administration%20Toolkit_122707.pdf.
[56] Ibid.
[57] Bridges to Excellence. Bridges to Excellence Launches Medical Home Program. Available: http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=119.

Several states have already, or are in the process of, implementing P4P initiatives as part of a larger statewide healthcare reform package. These programs are discussed in further detail in the 'State Initiatives in Provider Reimbursement' section of this paper.

Table 6. BTE Suggested Provider Reward Structure

Level of PRO Recognition (per patient per year)	Level I	Level II	Level III
Physician Office Link	$15	$30	$50
Diabetes Care Link (in POL regions / in non-POL regions)	$80 / $100	$160 / $200	N/A
Cardiac Care Link (in POL regions / in non-POL regions)	$80 / $100	$160 / $200	N/A
Spine Care Link	N/A	$50	N/A

Source: Bridges to Excellence. BTE Reward Administration Guidelines. 2007. Available: http://www.bridgestoexcellence.org/Documents/BTE%20Reward%20Administration%20Toolkit_122707.pdf.

Concerns and Limitations of P4P programs – There are several limitations that must be addressed when considering P4P implementation. Quality outcomes measures must be further defined and unified across a number of initiatives in order to provide validity to their use as well as simplifying reporting strategies.[58] Encouraging insurers to use the same quality measures would unify the system and simplify the reporting process for providers. Measurement systems that focus on individual providers rather than the larger system risk reinforcing the fragmentation and lack of coordination already inherent within our healthcare system.[59,60] There is a need for experimental system-wide P4P payment systems that include both hospitals and physicians.

It has also not been overwhelmingly documented that improvement in selected quality measures leads to better clinical outcomes. However, given that many P4P programs are process-oriented and encourage increased utilization of preventive procedures, these data may not be available for many years post-implementation. An additional area of uncertainty lies in the bonus payment itself. In many cases it is unknown whether the potential bonuses will be sufficient to compensate for the collection of data or to motivate change in the way providers care for patients.[61]

P4P programs also run the risk of becoming a significant burden for smaller hospitals. Small and/or rural hospitals may require different sets of quality measures in order for system-wide P4P programs to be equitable.[62] Also, if providers must attend to a number of tasks with a limited amount of resources, they may focus on the tasks that are explicitly rewarded to the detriment of those that are not.[63]

[58] Nichols LM, op. cit.
[59] Fisher ES. Paying for Performance – Risks and Recommendations. New England Journal of Medicine. 2006; 355(8): 1845-1847.
[60] Rosenthal MB, op. cit.
[61] Fisher ES, op. cit.
[62] Nichols LM, op. cit.
[63] Rosenthal MB, op. cit.

Academic centers and teaching hospitals may be at a disadvantage since physicians at these institutions spend time teaching medical students and residents.[64] Depending on how the quality measures are defined, time spent teaching could falsely give the appearance that such institutions are less efficient. P4P initiatives must also avoid penalizing hospitals in locations where there may only be one service provider. Using an absolute level of performance as opposed to performance improvement to measure quality may unintentionally penalize hospitals that have fewer resources and poorer performance at baseline.[65] Lastly, if physicians are not convinced that appropriate risk adjustment is being performed, they may avoid treating sick or challenging patients in order to achieve high quality scores.[66] It should be noted, however, that the Institute of Medicine has recognized all of these limitations, but still recommends moving forward with implementation of P4P programs as a strategy for improving the quality of care.[67]

State initiatives in provider reimbursement

Minnesota – The Minnesota Health Care Transformation Task Force has created a payment reform strategy that would separate healthcare facilities and payment associated with each into three levels. Level 1 explicitly ties payment to quality of care outcome measures. Level 2 establishes care management payments to providers who have demonstrated that they have the necessary infrastructure to provide coordinated patient care and act as a medical home. It has not been determined if the providers in level 1 and 2 will receive payment based on FFS or an episode-of-care system, however, the recommendations call for payers and providers to establish "baskets" of care. Reimbursement based on baskets of services would move the system away from FFS and towards an episode-of-care structure. Level 3 creates a system wherein the providers are accountable for the total cost of care through a capitation payment structure. Providers in level 3 will submit bids to insurance plans for the total cost of care for a standard benefit set for a given population. The provider will then responsible for providing all care for that population, as outlined in the benefit set, for the price negotiated with the insurance plan.

Payment in all levels will also be tied to quality outcomes, and payment for levels 2 and 3 will be risk-adjusted. Additionally, it is recommended that payment levels for primary care, care management, and other cognitive services be increased relative to other services in a cost-neutral manner. It is expected that all health care providers will be participating in the level 3 payment structure by 2012 at which time the state will have realized $4393 million in savings due to this piece of reform.[68]

In addition to the task force reform, the Minnesota Department of Human Services (DHS), acting as a large purchaser, has endeavored in several healthcare reform strategies including P4P. Q-Care is a statewide program that implements quality of care standards and defines a payment structure to reward quality of care as opposed to quantity of services. DHS requires that the

[64] Nichols LM, op. cit.
[65] Ibid.
[66] Fisher ES, op. cit.
[67] Ibid.
[68] Health Care Transformation Task Force. Recommendations Submitted To: Governor Tim Pawlenty and the Minnesota State Legislature. January 2008.

MCOs with which they contract adopt and implement quality guidelines as recommended by Q-Care.[69]

The Minnesota DHS and the Minnesota State Employees Group Insurance Program (SEGIP) have implemented the P4P program Bridges to Excellence (BTE). This is the same program that was discussed previously in the P4P section of this report. Currently, the program is only assessing diabetic care management. However, SEGIP estimated that for every dollar it has spent on provider rewards and program administration, it has achieved $5.60 in savings.[70]

Lastly, the Minnesota DHS is seeking to create medical homes for all patients covered by public health care programs. Within each medical home, primary care providers will receive a care coordination payment of $50 per member per month to coordinate the care of chronically ill patients within the DHS FFS program. Over time, this payment will be adjusted to reflect the complexity of the patient's illness and healthcare needs. A P4P program will also be incorporated into this system.[71]

Colorado – The Colorado Blue Ribbon Commission for Health Care Reform recently recommended to the Colorado state legislature that Colorado restructure its healthcare system to provide a medical home for all its citizens. It recommended reimbursing providers for care coordination and case management, while also paying providers based on their use of care guidelines, quality performance measures, and the use of health information technology. Moreover, it called for increasing Medicaid provider reimbursement to at least 75% of the Medicare reimbursement rates.[72] It should be noted that most of the state healthcare reform plans reviewed, in addition to those mentioned here, include raising Medicaid rates to more closely reflect those paid by Medicare.[73]

The Commission formulated its final recommendations based on the analysis of five healthcare reform proposals submitted by various agencies, including one from the Commission itself. Each plan had varying suggestions for provider reimbursement reform (Table 7). The savings demonstrated by the Solutions for a Healthy Colorado plan are achieved primarily by a large mandatory reduction in hospital payments for the privately insured. This mandate is not included in the other proposals.

[69] Minnesota Department of Human Services, Employee Relations, Health, and Commerce. Health Care Payment System Reform in Minnesota. December 14, 2007.
[70] Ibid.
[71] Ibid.
[72] Blue Ribbon Commission for Health Care Reform. Final Report to the Colorado General Assembly. January 31, 2008.
[73] Trinity M, Martinez-Vidal E, Friedenzohn I, et. al. State of the States. Academy Health. January 2008.

Table 7: Summary of Colorado Provider Reimbursement Proposals

Proposal	Key Features	Change in state spending* (billions)
Better Health Care for CO	1. Medicaid and CHP+ service providers paid at current Medicaid and CHP+ payment levels. 2. Payment rates for private insurance would be 130% of Medicare payment levels.	$65.0
Solutions for a Healthy CO	1. Increase payment rates for Medicaid to Medicare payment levels 2. Private sector payment levels would vary between 125 and 150% of Medicare payment levels based on a P4P program.	($558.0)
A Plan for Covering All Coloradans	1. Increase payment rates for Medicaid to Medicare payment levels 2. Payment for private insurance would be based on current private sector rates.	$412.0
CO Health Services Program	1.Single-payer program 2. Provider payment levels set to the average level of reimbursement across all payers for health care services.	$0.0
The Commission Proposal	1. Increases Medicaid payment levels to 75% of Medicare payment levels. 2. Private sector payment levels based on current private sector rates.	$137.0

*Changes in statewide health spending with regard to provider reimbursement based on reductions in uncompensated care, provider reimbursement levels, and changes in cost-shift.
Source: Blue Ribbon Commission for Health Care Reform. Final Report to the Colorado General Assembly. January 31, 2008.

Vermont – The Vermont Health Care Reform Commission recently proposed implementation of an accountable care organization (ACO) pilot program. This complements the work the state has already completed under its Blueprint for Health, which is based around the medical home model. An ACO, as described by Fisher, is a virtual organization composed of local hospitals and the physicians that work within and around them.[74] Fisher proposes using these organizations as the locus of accountability for a community's healthcare system. The ACO would make all data pertaining to cost, resource utilization, and performance publicly available. The community would then be responsible for holding the organization accountable for using its resources in the most efficient and effective manner. This model focuses on the efficiency of the system as a whole as opposed to individual providers. It is thought that this approach may begin to unify the fragmented healthcare system.

[74] Fisher EM, Staiger DO, Bynum JPW, et. al. Creating Accountable Care Organizations: The Extended Hospital Medical Staff. Health Affairs, web exclusive. 2007; 26(1): w44-w57.

Provider reimbursement for the proposed pilot would be paid on a FFS basis using current provider rates; a common fee schedule would not be established. The ACO as a whole would have the opportunity for additional payment if the total actual expenses of the ACO's patient population were less than the predetermined global budget. This budget would be an actuarially based per member per month 'capitation' multiplied by the number of patients within the ACO. If the ACO retained the additional payment, it would have the freedom to choose how it allocated its savings between providers and structural improvements.[75]

Conclusion

The current structure of provider reimbursement, based primarily on a FFS system, does not reward providers for rendering high-quality, efficient care and, often times, provides incentive to over-treat patients. This approach does not produce better health outcomes nor is it sustainable. The primary method of provider reimbursement must migrate towards one that rewards providers for quality and efficiency.

Although many examples of reimbursement reform provided in this paper were aimed at inpatient hospital settings, these same methods could be utilized for primary care or other outpatient venues. In all settings, the payment structure must account for factors contributing to the cost of care, differences in patient populations, and the severity of illness. The framework under which a payment system is devised also determines the amount of risk that will be assumed by both the payer and the provider.

The OHFB has been commissioned with developing a comprehensive healthcare reform plan that supports the use of medical homes as a primary means of care coordination. A large piece of this task is to create a method of provider reimbursement that promotes the goals of the Healthy Oregon Act and the guiding principles of the Medical Home Model. In doing so, the board could consider developing a system that:

1. ***Rewards providers for health outcomes and improvement in quality of care.*** This most likely would involve implementation of a P4P program. The incentives could be linked to either outcome or process measures.

2. ***Adequately compensates providers for care coordination and management services.*** These services are not always covered under a FFS system. Adequate reimbursement of such services could lead to a system with a greater focus on prevention, and ultimately, a healthier population.

3. ***Is transparent to payers and providers.*** Payers should be given information that is sufficient to tell exactly what services are provided for a given cost. At the same time, providers should know what services they are responsible for rendering.

[75] Vermont Health Care Reform Commission. Vermont Pilot of Community Based Payment Reform: Accountable Care Organization. March 7, 2008.

4. ***Is sustainable.*** Reimbursement levels could be set in a manner that is sustainable for the system. An evaluation mechanism could be established to review payment levels and ensure that providers are being adequately reimbursed for their services while also keeping costs affordable to the payer.

5. ***Adjusts for risk based on incidence of illness in a given population.*** In order to develop a system that is equitable, reimbursement could be provided in a manner that does not penalize providers that care for patients who are sicker than the average citizen. On the same note, the system should not be established to allow providers or insurance carriers to select healthier or wealthier patrons.

6. ***Builds on the experiences of other reforms at the local, state, and national level as well as the private sector.*** Oregon can learn from the experiences and data produced by other initiatives that address many of the same goals as the Healthy Oregon Act. Building partnerships with these collaboratives could advance healthcare reform as a whole and position the Oregon Health Fund Program for success.

Health Care Transformation Task Force

Recommendations Submitted To:
Governor Tim Pawlenty
And the
Minnesota State Legislature
January 2008

Health Care Transformation Task Force Members
Co-Chairs:
Commissioner Cal Ludeman, Minnesota Department of Human Services
Representative Thomas Huntley
Task Force Members:
Peter Benner, formerly AFSCME
Senator Linda Berglin
Dr. Charles Fazio, Medica
Thomas Forsythe, General Mills
Michael Howe, Minute Clinic
Carolyn Jones, Governor Pawlenty's Office
Sean Kershaw, Citizens League
Paula Klinger, Hopkins School District
Tony Miller, Carol Inc.
Commissioner Dr. Sanne Magnan, Minnesota Department of Health (Ex Officio)
Charles Montreuil, Carlson Companies
Dr. Maureen Reed
Senator Julie Rosen
Representative Paul Thissen
David Wessner, Park Nicollet
Dr. Scott Wright, Mayo Clinic

The complete report with recommendations can be obtained at:

http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf

"Simplify pricing of health care services to make it easier for consumers to understand and use cost information. For people with private insurance, providers would no longer receive different prices for services depending on what health insurance plan a patient has. Health plans and providers would no longer negotiate over price discounts, and health plans would structure benefits so that consumers would pay more out of pocket for using higher-cost providers....

Single Price Policy Concept

All hospitals and health care professionals would be required to establish a single price for each service they provide. This price would apply to all private and commercial purchasers (individual self-pay, insured and self-insured contracts).

The price charged for a service would be the same for all private payers. Discounts would be prohibited.

Prices established by providers would be publicly available through a state website, each third party payer and from the provider. Consumers (patients), purchasers, payers and other providers would see the posted prices and would be able to compare prices. Year-over-year changes in prices between providers would be transparent.

Third party payers would not negotiate with providers for different prices. They would be permitted, however, to establish maximum allowable payment ceilings based on the range of filed prices and annual increases to filed prices. Payers could create various benefit designs with higher reimbursement (lower point-of-service cost sharing by patients) to providers with lower prices and lower annual price increases.

The price of a service (and the annual rate of increase in the price) would be transparent; not hidden in the opaque negotiations between providers and payers.

Hospital	3 year ave. GPR (2004-2006)		
Tri County			
Providence St. Vincent Medical Center	1,085,827,522		
Providence Portland Medical Center	855,707,004		
Providence Milwaukie Hospital	119,074,452		
Providence Tri County		2,060,608,978	
Legacy Emanuel Hospital	727,017,495		
Legacy Good Samaritan Hospital and Medical Center	394,186,568		
Legacy Meridian Park Hospital	191,527,877		
Legacy Mt. Hood Medical Center	118,073,485		
Legacy Tri County		1,430,805,425	
OHSU Hospital	1,162,908,690	1,162,908,690	
Adventist Medical Center	412,770,976		
Tuality Healthcare	259,500,285		
Willamette Falls Hospital	78,855,421		
Region Total	$5,405,449,775	$4,654,323,093	**86.1%**
Mid Valley			
Salem Hospital	524,772,311		42.0%
Willamette Valley Medical Center	149,253,750		
Silverton Hospital	101,104,058		
		775,130,119	
Good Samaritan Regional Medical Center (Corvallis)	291,914,109		
Samaritan Albany General Hospital	110,631,846		
Samaritan Lebanon Community Hospital	71,379,889		
Samaritan Health System		473,925,844	37.9%
Region Total	$1,249,055,963		
Lane County			**82%**
Sacred Heart Medical Center	634,597,757		
McKenzie-Willamette Medical Center	136,440,854		
Region Total	$771,038,611		

Hospital	3 year ave. GPR (2004-2006)		
Jackson/Josephine			
Rogue Valley Medical Center	463,122,332		
Three Rivers Community Hospital and Health Center	197,026,016		
Asante Health System		660,148,348	**71.3%**
Providence Medford Medical Center	207,143,818		
Ashland Community Hospital	59,118,108		
Region Total	$926,410,274		
Other			
St. Charles Medical Center (Bend)	378,908,237		
Mercy Medical Center (Roseburg)	294,644,133		
Merle West Medical Center (Klamath Falls)	225,805,285		
Bay Area Hospital (Coos Bay)	189,717,935		
All Oregon Hospitals	10,537,472,164		
Total of 27 Hospitals Listed Above	$9,441,030,213	89.6%	

Oregon Health Fund Board

Quality Institute Work Group

Report to the Delivery Systems Committee

April 10, 2008

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Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Report Index

Oregon Health Fund Board — Delivery Systems Committee Quality Institute Work Group

Preamble

Ongoing quality assessment and a process for quality improvement is the keystone of any viable health care system. An Oregon Quality Institute will serve as a leader to unify existing quality efforts and lead Oregon toward a higher performing health care delivery system. Long term, stable state investment in and dedication to quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient, and equitable.

I. Background

Based on recommendations from the Oregon Health Policy Commission (OHPC), Senate Bill 329 (2007), the Healthy Oregon Act, directs the Administrator of the Office for Oregon Health Policy and Research to develop a model Quality Institute for Oregon as part of the larger health reform planning process established by the bill. The Oregon Health Fund Board assigned this task to the Delivery Systems Committee and chartered a Quality Institute Work Group to develop recommendations regarding the appropriate structure and roles for an Oregon Quality Institute. The Quality Institute would coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery.

The preamble of SB 329 calls for health reform policies that encourage the use of quality services and evidence-based treatments that are appropriate, safe and discourage unnecessary treatment. Research illustrates that the current health care delivery system in Oregon does not consistently deliver high-quality care or effectively use resources to deliver evidence-based care to Oregonians. For instance, only 40% of adults over 50 receive recommended preventive care, and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia.[1] In addition, quality of care varies significantly depending on where in the state a patient receives care, as does the utilization of specific procedures and treatment options.[2] While there are numerous public and private efforts underway across the state to

[1] Cantor JC, Schoen C, Belloff D, How SKH, and McCarthy D. Aiming Higher: Results from a State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System, June 2007.

[2] Performance Report for Chronically Ill Beneficiaries in Traditional Medicare: Hospitals – Oregon. Provided by Elliot Fischer and the Dartmouth Atlas Project.

improve health care quality, SB 329 points to the need for a Quality Institute to serve as a leader and to unify existing efforts in the state around quality and transparency.

The availability of clear and transparent information is the keystone to any health care reform plan, including the current effort to improve the quality of care delivered by Oregon's health care system. The Institute of Medicine's Ten Rules to Redesign and Improve Care calls for shared knowledge and the free flow of information and transparency across the health care system.[3] In addition, President Bush's Four Cornerstones for Healthcare Improvement Executive Order of 2006 calls for greater health system transparency through wider availability of health care quality and price data.[4] Providers need better information to benchmark their performance, identify opportunities for quality improvement and design effective quality improvement initiatives. Purchasers need ways to identify and reward high-performing providers who delivery high-quality, high-value care to their patients. Consumers need better cost and quality information to help guide critical health care decisions. Therefore, an Oregon Quality Institute is needed to ensure that appropriate and actionable information is available across the health care system and that stakeholders have the tools and knowledge needed to use this information to improve quality of care. A collaborative and well-supported effort to improve quality and increase transparency is a vital part of any effort to transform Oregon's health care delivery system into a high-performing, high-quality system that meets the health care needs of all Oregonians.

II. Recommendations for a Model Oregon Quality Institute

The Quality Institute Work Group of the Oregon Health Fund Board Delivery Systems Committee recommends the formation of a Quality Institute for Oregon. The Institute will be established as a publicly chartered public-private organization, giving it legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have rulemaking abilities and statutory authority and protections. The Quality Institute must provide strong confidentiality protections for the data it collects and reports and must provide the same protections to information submitted by other organizations.

The Work Group makes the following recommendations about the structure, governance and funding for a Quality Institute for Oregon:

- A Board of Directors of the Quality Institute will be appointed by the Governor and confirmed by the Senate and include no more than 7 members. Members must be knowledgeable about and committed to quality improvement and

[3] Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. (2001). National Academy Press: Washington, DC.
[4] U.S. Department of Health and Human Services, Value-Driven Health Care Home. http://www.hhs.gov/valuedriven/index.html

represent a diverse constituency. The Board should be supported by advisory committees that represent a full range of stakeholders. The Administrator of the Office for Oregon Health Policy & Research, or a designee, shall serve as an Ex-Officio member of the Board.

- The Quality Institute will have an Executive Director, who is appointed by and serves at the pleasure of the Board. The Quality Institute will have a small professional staff, but should partner or contract with another organization to provide administrative support.
- In order for the Quality Institute to be stable, state government must make a substantial long-term financial investment in the Quality Institute by providing at least $2.3 million annually for a period of at least 10 years (See Appendix C). Following the 2009-11 biennium, this budget should be adjusted to account for inflation.
- The Quality Institute will partner and collaborate with other stakeholders to maximize output and minimize duplication of efforts. In addition, nothing precludes the Quality Institute from seeking additional voluntary funding from private stakeholders and grant-making organizations to supplement state appropriations.

The Quality Institute's overarching role will be to lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission). To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported, and goals will be regularly updated to encourage continuous improvement.

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities.

3. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and

patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives.

4. Ensure the collection (by coordinating and consolidating collection efforts and directly collecting data when not available) and timely dissemination of meaningful and accurate data about providers, health plans and patient experience. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, health plans, and other members of the public in appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting whenever possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data and/or may support other organizations in publishing data.

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate.

As the budget of the Quality Institute allows, the Board of the Quality Institute should use data and evidence to identify opportunities to improve quality and transparency through the following activities (either directly carried out by the Quality Institute or in partnership with other stakeholder groups):

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered.

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures.

- Lessen the burden of reporting that currently complicates the provision of health care.

- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement.

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care and evaluate quality improvement initiatives.

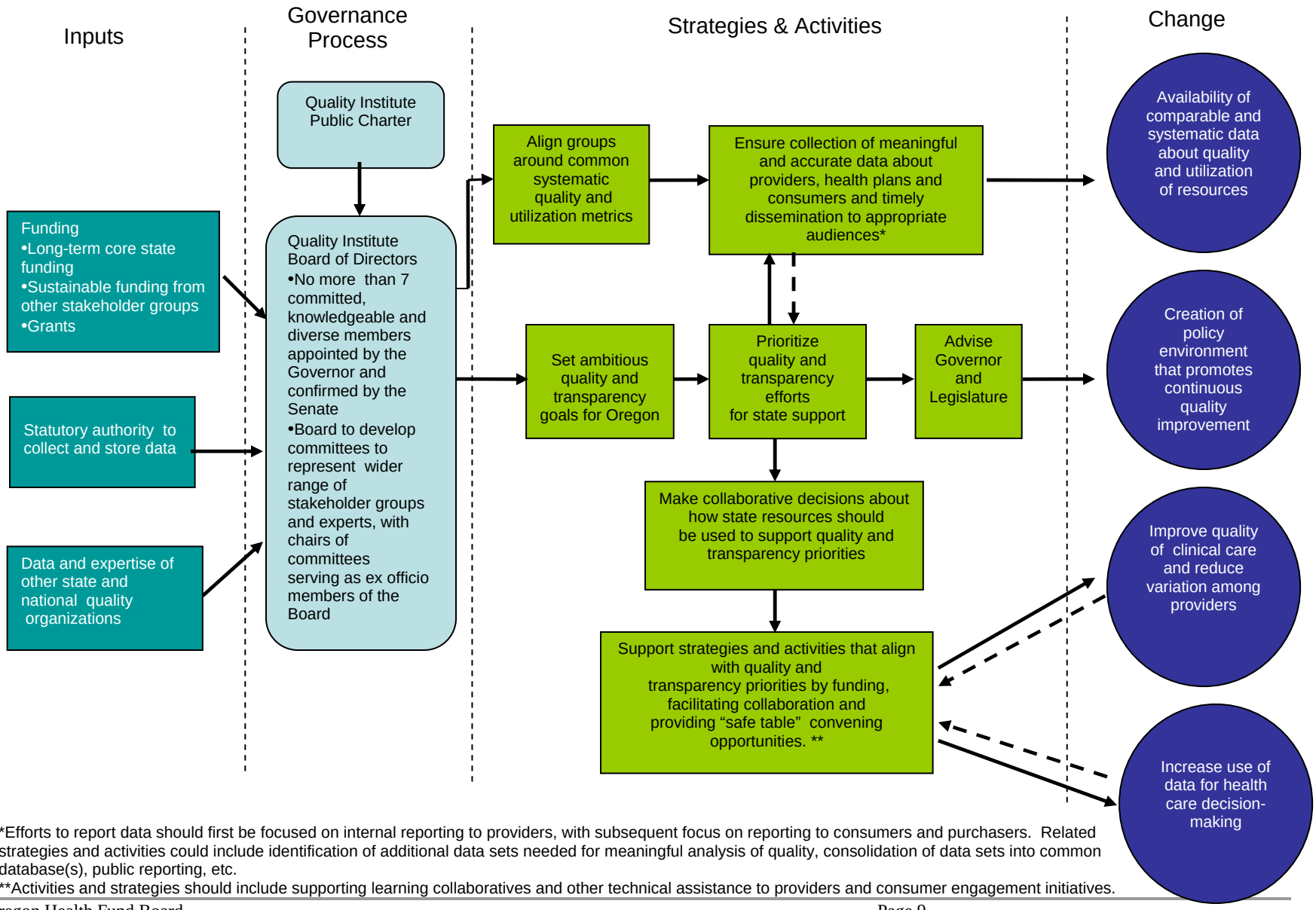
- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health.

III. Logic Model for an Oregon Quality Institute

The Quality Institute Work Group constructed a "theory of change" logic model to provide a pictorial representation of its recommendations for an Oregon Quality Institute. The logic model attempts to represent the range of inputs, governance process, strategies and activities the group believes would be required to develop a Quality Institute successful in achieving the following goals:

- Ensure availability of comparable and systematic data about quality and utilization of resources;
- Create a policy environment that promotes continuous quality improvement;
- Improve the quality of clinical care; and
- Increase the use of quality data for health care decision-making.

Logic Model for a Quality Institute for Oregon



*Efforts to report data should first be focused on internal reporting to providers, with subsequent focus on reporting to consumers and purchasers. Related strategies and activities could include identification of additional data sets needed for meaningful analysis of quality, consolidation of data sets into common database(s), public reporting, etc.

**Activities and strategies should include supporting learning collaboratives and other technical assistance to providers and consumer engagement initiatives.

IV. Work Group Process

The Quality Institute Work Group began their formal deliberations in December of 2007 and held seven meetings. Membership was drawn from a wide range of stakeholder groups and included many of the same people who served on the Oregon Health Policy Commission Quality and Transparency Work Group.

At its first substantive meeting in January 2008, the group was joined by Dennis Scanlon, Assistant Professor in Health Policy and Administration at Penn State University, who is a member of the team evaluating the Robert Wood Johnson Foundation's Aligning Forces for Quality program. Dr. Scanlon suggested a framework for approaching the Work Group's charge, discussed 'Theory of Change' models of behavior change and presented examples and results of quality improvement efforts from around the country. Carol Turner, a facilitator from Decisions Decisions in Portland, facilitated five of the work group's meetings.

In an effort to identify existing gaps in quality and transparency efforts in Oregon and identify possible areas for collaboration and coordination, the work group built on efforts of the Oregon Health Policy Commission Quality and Transparency Work Group to assess the current landscape in Oregon. The following organizations and collaborative initiatives dedicated to quality improvement and transparency were identified and discussed:

- Acumentra Health
- Advancing Excellence in America's Nursing Homes
- Compare Hospital Costs Website
- Department of Human Services
- The Foundation for Medical Excellence
- Health Insurance Cost Transparency Bill – HB 2213 (2007)
- The Health Care Acquired Infections Advisory Committee
- Independent Practice Associations and Medical Groups
- Oregon Association of Hospitals and Health Systems
- Oregon Chapter of the American College of Surgeons
- Oregon Coalition of Health Care Purchasers
- Oregon Community Health Information Network (OCHIN)
- Oregon Health Care Quality Corporation
- Oregon Health and Sciences University Medical Informatics
- Oregon Hospital Quality Indicators
- Oregon IHI 5 Million Lives Network
- Oregon Patient Safety Commission
- Oregon Primary Care Association
- Oregon Quality Community
- Patient Safety Alliance

- Public Employees Benefits Board and Oregon Educators Benefits Board
- Regence Blue Cross Blue Shield

Appendix A provides a matrix that describes these efforts.

The Work Group also examined quality and transparency efforts in other states, focusing on initiatives in Maine, Massachusetts, Minnesota, Pennsylvania, Washington, and Wisconsin. Appendix B provides a description of select quality and transparency efforts in these states.

V. Definitions of "Quality" and "Transparency"

When the Work Group reviewed its charter from the Oregon Health Fund Board at its first meeting, members quickly identified a need to develop standard definitions of *quality* and *transparency*.

Members noted that a number of organizations in Oregon, including the Oregon Health Care Quality Corporation, have incorporated the Institute of Medicine's (IOM) definition of quality, which includes the six domains of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Members also acknowledged the work of the U.S. Department of Human Services' Agency for Healthcare Research and Quality (AHRQ) in the area of quality. On January 3, the Work Group approved the definition of *quality* found below, which combines definitions presented by the IOM and AHRQ.

Quality

As defined by the Institute of Medicine (IOM), quality is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In the 2001 Crossing the Quality Chasm, the IOM defined a high quality health care system as one that is:

- **Safe –** avoiding injuries to patients from the care that is intended to help them.
- **Effective –** providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- **Patient-centered –** providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely –** reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient –** avoiding waste, including waste of equipment, supplies, ideas, and energy.

- **Equitable –** providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

AHRQ has summarized this definition of quality as meaning doing the right thing at the right time, in the right way, for the right person and getting the best results.

The group could not identify a widely accepted definition of *transparency* and had to combine language from various sources with members' best thinking. The concept of "clarity in relationships" was taken from a 2006 article about transparency in health care that appeared in the American Heart Hospital Journal.[5] The Work Group approved the definition below on January 10.

Transparency
A transparent health care system provides clarity in relationships among patients, providers, insurers and purchasers of health care. ***To the extent practicable and appropriate, a transparent system makes appropriate information about patient encounters with the health care system, including quality and cost of care, patient outcomes and patient experience, available to various stakeholders in appropriate formats.*** This includes, but is not limited to, providing consumers and other health care purchasers with the information necessary to make health care decisions based on the value of services (value = quality/cost) provided and giving providers the tools and information necessary to compare performance. In a transparent system, health care coverage and treatment decisions are supported by evidence and data and made in a clear and public way.

VI. Problem Statement

The Quality Institute Work Group also drafted a statement of the problems in the current health care system that could potentially be addressed by an Oregon Quality Institute:

- Need for a robust mechanism to coordinate statewide quality improvement and transparency efforts. Currently, we have:
    - Multiple agencies, organizations, providers and other stakeholder groups furthering quality and transparency efforts, without unifying coordination
    - No mechanism for setting common goals around health care quality or a public quality agenda
    - A need for stronger mechanism for sharing of best practices, successes and challenges across efforts

[5] Weinberg SL. Transparency in Medicine: Fact, Fiction or Mission Impossible? Am Heart Hosp J. 2006 Fall;4(4):249-51.

  - Missed opportunities for synergy, efficiency, and economies of scale possible through partnership along common goals
- No comprehensive measurement development and measurement of quality across the health care delivery system
  - Consumers and purchasers have limited access to comparable information about cost and quality
  - Providers have limited ability to compare their own performance with peers and to make referral decisions based on quality and cost data
  - Providers are required to report different measures to different health plans and purchasers
- Limited resources dedicated to quality improvement and transparency
  - Lack of resources to support coordination across quality and transparency efforts
  - Providers have limited resources to build infrastructure needed to support data collection, reporting and analysis
  - Need for systemic mobilization and planning for use of resources in a manner that maximizes system wide impact and reduces duplicative efforts
- Wide variability between providers in quality and cost of care
- Lack of infrastructure (both human and technology) necessary to assess system wide performance and use data to develop a systemic approach to quality improvement
- Lack of systematic feedback and credible data to improve clinical care systems
- Need for new tools to help consumers, purchasers, and providers effectively use data to make treatment and coverage decisions

VII. Assumptions

The Quality Institute Work Group next worked to clarify the starting assumptions that the group would use to identify the appropriate roles and structure of an Oregon Quality Institute. The starting assumptions went through a number of iterations and the group approved the set below.

Assumption 1*:* The Quality Institute will coordinate, strengthen and supplement current and ongoing initiatives across Oregon to create a unified effort to improve quality, increase transparency, and reduce duplication across stakeholder groups. Quality improvement and increased transparency will lead to a health care system that is safer, more effective, patient-centered, timely, efficient and equitable, and better able to contain costs.

Assumption 2: The Quality Institute will be an essential element of any sustainable health care reform plan and should play an integral and long-term role in improving quality and increasing transparency across Oregon.

Assumption 3: The collaborative nature of the Quality Institute and the strengths of the range of stakeholders will allow the Institute to capitalize on a variety of strategies to further the quality and transparency agenda. These strategies include, but are not limited to, market based approaches, provider collaboration, consumer engagement and regulatory approaches. Different partners will have the authority and capacity to utilize different strategies, depending on function and target audience. These partnerships should be developed in a manner that allows for assessment of the fundamental capabilities of the health care system in Oregon, identification of opportunities to effect change across the system, and monitoring of quality improvement and cost savings from quality improvement across the entire system.

Assumption 4: The Quality Institute will need to be supported by sustainable, stable and sufficient resources if it is to be an effective agent for change in improving quality and increasing transparency in the health care system. A broad base of funding, including dedicated public resources and resources from other stakeholders, will be necessary to make progress in quality and transparency.

VIII. Roles of the Quality Institute

The next task for the Quality Institute Work Group was to make recommendations about the appropriate roles of a Quality Institute for Oregon, given the group's problem statement and assumptions. Staff created a draft list of potential roles, based on quality improvement strategies used in other states, as well as other published sources, including the IOM's 2005 report to Congress calling for the establishment of a National Quality Coordination Board.[6] The initial draft list included twelve possible roles, which were categorized using a framework presented by Dennis Scanlon. Each option was categorized by the primary strategies it would utilize (market-based approach, collaborative quality improvement approach, patient/consumer education/engagement, and regulatory approaches), domains of improvement it would address (safety, effectiveness, patient-centeredness, timeliness, efficiency, equity) and target audience(s).

The facilitator led the group in several rounds of discussion and revision of the role options, with the group analyzing each proposed role, adding additional roles, scoring roles, eliminating roles that were not appropriate for a Quality Institute and combining roles that were redundant. In addition, the group developed a framework for categorizing roles that fall under the auspices of the Quality Institute. The categories

[6] Institute of Medicine. (2005). Performance Measurement: Accelerating Improvement. National Academies of Press. Washington, D.C.

the group settled on were *Coordination and Collaboration, Systematic Measurement of Quality, Provider Improvement and Technical Assistance, Consumer Engagement and Policy Advising.*

The Work Group also identified some of the roles as priorities that should guide the Quality Institute in its initial work. These roles focus on establishing a coordinated quality and transparency agenda for Oregon and developing a systematic performance measurement process. Once the Quality Institute is successful in achieving these goals, members felt that the Quality Institute should use data and evidence to determine where initiatives related to the remaining roles could be most effective. The Quality Institute's budget will determine the extent to which the Institute is able to pursue these additional roles.

Overarching Role

The Quality Institute will lead Oregon toward a higher performing health care delivery system by initiating, championing and aligning efforts to improve the quality and transparency of health care delivered to Oregonians. Some of this work will be directly carried out by the Quality Institute, while some will be completed in partnership with existing organizations (e.g. The Oregon Health Care Quality Corporation or Oregon Patient Safety Commission).

To achieve its goals, the Quality Institute will first pursue the following priorities:

1. Set and prioritize ambitious goals for Oregon in the areas of quality improvement and transparency. Progress toward achieving these goals will be measured and publicly reported and goals will be regularly updated to encourage continuous improvement (Coordination and Collaboration).

2. Convene public and private stakeholders to align all groups around common quality metrics for a range of health care services. Metrics adopted for Oregon will be aligned with nationally accepted measures that make sense for Oregon. In developing common metrics, the benefit of reporting particular datasets to align with adopted quality metrics must be balanced against the burden of collecting and reporting these measures from health care facilities (Coordination and Collaboration).

3. Ensure the collection (by coordinating and consolidating collection efforts and directly collecting data when not available) and timely dissemination of meaningful and accurate data about providers, health plans and patient experience. Data should provide comparable information about quality of care, utilization of health care resources and patient outcomes. To the extent practicable and appropriate, data should be easily accessible to providers, health care purchasers, accountable health plans, and other members of the public in

appropriate formats that support the use of data for health care decision-making and quality improvement (right information to the right people at the right time). The Quality Institute shall establish a system for data collection, which shall be based on voluntary reporting to the greatest extent possible, but may include mandatory reporting if necessary. The Quality Institute may directly publish data or may support other organizations in publishing data (Systematic Measurement of Quality).

When developing a system and methods for public disclosure of performance information, the Quality Institute should consider the following criteria[7]:

- Measures and methodology should be transparent;
- Those being measured should have the opportunity to provide input in measurement systems (not be "surprised") and have opportunities to correct errors;
- Measures should be based on national standards to the greatest extent possible;
- Measures should be meaningful to consumers and reflect a robust dashboard of performance;
- Performance information should apply to all levels of the health care system – hospitals, physicians, physician groups/integrated delivery systems, and other care setting; and
- Measures should address all six improvement aims cited in the Institute of Medicine's Crossing the Quality Chasm (safe, timely, effective, equitable, efficient, and patient-centered).

4. Ensure providers have the ability to produce and access comparable and actionable information about quality, utilization of health care resources and patient outcomes that allows for comparison of performance and creation of data-driven provider and delivery system quality improvement initiatives (Provider Improvement and Technical Assistance).

5. Advise the Governor and the Legislature on an ongoing basis on policy changes/regulations to improve quality and transparency. Produce a report to be delivered each legislative session about the state of quality of care in Oregon to be provided to the Governor, Speaker of the House and the President of the Senate (Policy Advising).

As the budget of the Quality Institute allows, the Board of the Quality Institute should use data and evidence to identify opportunities to improve quality and transparency through the following activities (either directly carried out by the Quality Institute or in partnership with other stakeholder groups):

[7] Adopted from the Consumer-Purchaser Disclosure Project, a group of leading employer, consumer, and labor organizations working toward a common goal to ensure that all Americans have access to publicly reported health care performance information. For more information, see http://healthcaredisclosure.org.

- Participate in the development and assessment of new quality improvement strategies by championing, coordinating, funding and/or evaluating quality improvement demonstration and pilot projects. In addition to projects focused on improving the delivery of care, projects that explore opportunities to provide incentives for quality improvement should be considered (Coordination and Collaboration).

- Convene public and private stakeholders to identify opportunities to develop a collaborative process for endorsing and disseminating guidelines of care and assessing the comparative effectiveness of technologies and procedures (Coordination and Collaboration).

- Lessen the burden of reporting that currently complicates the provision of health care (Provider Improvement and Technical Assistance).

- Support learning collaboratives and other technical assistance for providers to develop and share best practices for using data to drive quality improvement. Disseminate proven strategies of quality improvement (Provider Improvement and Technical Assistance).

- The Governor's Health Information Infrastructure Advisory Committee (HIIAC) will be making recommendations to the Oregon Health Fund Board about a strategy for implementing a secure, interoperable computerized health network to connect patients and health care providers across Oregon. The Quality Institute should align itself with these recommendations and support efforts to develop and facilitate the adoption of health information technology that builds on provider capacity to collect and report data and ensure that the right information is available at the right time to patients, providers, and payers. The Quality Institute should also partner with the HIIAC and other efforts within Oregon and across the country to build provider and system capacity to effectively use health information technology to measure and maximize quality of care, and evaluate quality improvement initiatives. (Provider Improvement and Technical Assistance).

- Support efforts, in partnership with providers, to engage consumers in the use of quality and utilization data and evidence-based guidelines to make health decisions. Support efforts to engage patients in taking responsibility for their own health (Consumer Engagement).

Discussion: Much of the discussion surrounding the roles of a Quality Institute focused on the need to take a long-term approach to quality improvement and to establish an institute with at least a 10-year vision, supported by the funding and resources required

to achieve that vision. Members expressed the need to ensure that all stakeholder groups and policymakers maintain realistic expectations about how quickly quality improvement efforts could move ahead and how difficult it is to move the needle in the quality arena. While the group discussed the need for the Quality Institute to find some short-term wins, there was consensus that the state government, as well as all other stakeholders will need to make a long-term commitment to the goals of improved quality and increased transparency.

In developing recommendations for the appropriate roles for a Quality Institute, the group spent significant time discussing the types of data that would be most useful to stakeholders in assessing quality and driving quality improvement efforts. There was general agreement that cost is one of the potential factors important to the assessment of efficiency. An example considered by the group was the use of generic medication. Cost is part of the value equation (value = quality/cost), but members were aware that it is also a more complex indicator than often realized. Some members cautioned that reporting cost data alone does not provide useful "apples to apples" comparisons, as costs associated with particular medical services are influenced by many different factors including patient mix, negotiated rates, staff mix and the burden of uncompensated care. For instance, simply comparing the average price of normal births at two different hospitals would not account for these differences. There were a few members that expressed the view that this information should still be made available with clear explanations of its limitations, but there was general consensus among the members that the Quality Institute should focus on collecting and reporting data directly related to the quality and efficiency of care. The group agreed that an analysis of geographic variations in utilization of health care resources can provide important insight into quality and thus is an appropriate role of a Quality Institute. Members highlighted the value of work done at the Dartmouth Atlas Project in describing variation in health resource utilization between hospitals serving Medicare patients. [8]

The Work Group discussed a number of different strategies and activities that the Quality Institute might decide to use to ensure the collection and timely dissemination of systematic data about quality and utilization. While the group decided that the Board of the Quality Institute will determine how best to fulfill this role, the group discussion highlighted some important decisions that will have to be made by the Quality Institute Board. While some members believed it would be appropriate for the Quality Institute to build and maintain (either directly or through a vendor contract) a common database to consolidate all of the quality data in the state and reduce duplicative reporting to various sources, others believed that this would not be the best way to utilize resources. Alternatively, members suggested that the Quality Institute could analyze data sets already collected by various stakeholder groups and identify

[8] For more information, see http://www.dartmouthatlas.org/

additional data sets needed for meaningful and complete analysis of quality. In particular, the group highlighted the need for the Quality Institute to identify opportunities to use and/or develop data sources that provide information about patient experience and measure quality of life and functionality from health care interventions. Members did agree that in its analysis of quality and resource utilization, the Quality Institute will first use administrative data sets, as these are currently available, but that the Institute must acknowledge the limitations of this type of data. The Quality Institute should support efforts of other organizations and clinical societies to develop more robust and representative data sets that are validated, use national benchmarks that are based on prospective, risk-adjusted, physiologic data, and it should utilize these data sets as they become widely available.

After confirming the list of roles, the group talked about the need to stage the work of the Quality Institute and prioritize certain roles over others. The group decided there were three main audiences for the work of the Quality Institute – providers, purchasers and consumers – and that each would benefit from different types of information presented in different formats. In general, the group decided that the first goal must be to develop the infrastructure necessary to systematically measure quality over time and in a timely manner. The group then reached general consensus that the Quality Institute would be most effective if it first focused on the provider community and subsequently on purchasers and consumers (see logic model above).

Members acknowledged the ambitious agenda they established for the Quality Institute and emphasized the need for the Quality Institute Board to prioritize its work based on the quality and transparency goals it sets out for the state. In developing systematic measurements of quality, the Work Group suggested that the Board select particular areas of initial focus, such as the five most prevalent chronic conditions, the integrated health home and/or behavioral health. In addition, members suggested that as the Quality Institute begins its effort to support the provider community in quality improvement, the group should look to expand participation in evidence-based, validated programs that have already been developed and tested by professional associations and organizations. For instance, members highlighted the success of the National Surgical Quality Improvement Program (NSQIP), as an example of a program that has been able to get various stakeholders to collaborate around common quality improvement goals and has been widely tested, validated and benchmarked (See Oregon Chapter of the American College of Surgeons in Appendix A.)

IX. Financing, Structure and Governance

In an attempt to build a framework in which to make decisions about the best governance structure for a Quality Institute, the Work Group determined the following set of criteria:

- Mission – The Institute must have clear and focused mission;

- Stable and adequate funding – The Institute must have long-term core funding from public sources;
- Legislative support – Government must be a leader and a better partner that challenges other stakeholders to join a unified effort to improve quality;
- Unbiased – Stakeholders must be represented in the planning, execution and evaluation processes;
- Legitimacy – The Institute must be trusted by stakeholder groups;
- Accountable – The Institute must be required to measure and demonstrate effectiveness of efforts; and
- Flexibility – The Institute must be able to utilize an efficient and timely decision-making process and have the capacity to drive change.

The Work Group discussed the advantages and disadvantages of various governance models including public, public-private and strictly private models by analyzing the structure, funding and governance of existing organizations within each category. The group ultimately decided that a publicly chartered public-private organization would give the Quality Institute legitimacy and a well-defined mission, while allowing for flexibility in operations and funding. In addition, this structure will allow the Quality Institute to accept direct state appropriations and have rulemaking abilities and statutory authority and protections. The Quality Institute must provide strong confidentiality protections for the data it collects and reports, and it must provide these same protections to the information submitted by other organizations.

In discussing the makeup of a Board of Directors for the Quality Institute, the Work Group members stressed the importance of limiting the size of the group in order to allow for efficient decision-making. Therefore, the Work Group recommends that the Board be appointed by the Governor and confirmed by the Senate and be comprised of no more than seven members. Members must be committed to and knowledgeable about quality improvement and represent diverse interests (geographic diversity, public/private mix, experts and consumer advocates, etc). In an effort to ensure that a full range of stakeholders are given the opportunity to participate in the work of the Quality Institute, the Board should be able to create stakeholder and technical advisory committees, with chairs of these representative groups serving as ex officio members of the Board. In addition, the group recommends that the Board appoint the Executive Director, to serve at the pleasure of the Board.

In looking at the relationships the Quality Institute would have with other initiatives working to improve quality and transparency, Work Group members attempted to differentiate a number of different approaches the Institute would take in fulfilling its roles. Members agreed that in some cases the Institute would act as a "doer", while in others the Institute would be more likely to act as a "convener", "facilitator" or a "funder". The Quality Institute should act first and foremost as a convener that facilitates "safe table" opportunities for stakeholder groups to collaborate and work

towards consensus on quality-related issues and should be directly involved in setting the quality and transparency policy agenda for Oregon. It is likely that the Quality Institute will often direct, support and fund other organizations in implementing specific initiatives aligned with this agenda, as well as directly carrying out these efforts.

Work Group members agreed that the Quality Institute should be a lean organization, supported by a small professional staff, but that the Institute should partner or contract with a state organization or group with a similar mission to provide human resources, office operations and other administrative support. Members suggested that the Quality Institute explore opportunities to consolidate these functions with the Oregon Patient Safety Commission, Oregon Health Care Quality Corporation or another organization with a mission closely aligned to that of the Quality Institute. However, members noted that if the Quality Institute plans to provide grants and other assistance to outside organizations it would be important for these relationships to be designed in a way that did not create a conflict of interests.

The Work Group stressed the need for state government to provide long-term and sustainable funding for a Quality Institute and to lead other stakeholders in making a robust investment in quality improvement. In addition, nothing would preclude the Quality Institute from seeking additional voluntary funding from private sources to supplement state appropriations. However, Work Group members pointed out that many private stakeholders are already supporting quality improvement organizations and that the Quality Institute should strive to partner with those organizations rather than create parallel and duplicative efforts. The Quality Institute should also be able to receive grants from state and national foundations and agencies, but the Work Group warned that grants alone cannot provide a sustainable or sufficient funding source.

The group estimated that an investment from state government of at least $2.3 million per year over a 10-year period is needed to establish a Quality Institute for Oregon. This budget should be adjusted using the consumer price index or another tool that adjusts for inflation. Appendix C provides budgets for three options for a Quality Institute, one that focuses on data collection and reporting, a second that focuses on convening stakeholders, providing grants and technical assistance and a third combines all of these functions. The Quality Institute Work Group firmly believes that only the third model will provide the infrastructure and support needed to truly drive change and improve the quality and transparency of care delivered to Oregonians.

Appendix A: Organizations and Collaborative Efforts Dedicated to Quality Improvement and Increased Transparency in Oregon

Initiative/Quality Organization Name	Lead Stakeholders/General Structure	Description of Quality Initiative(s)	Major Funding Source(s)	Target Audience(s)
Acumentra Health	Acumentra Health is a physician-led, nonprofit organization that serves as the state's Quality Improvement Organization; partners with various state agencies, research organizations, professional associations and private organizations	Provides resources and technical assistance to Oregon's Medicare providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, and Part D prescription drug plans to support quality improvement (QI) efforts. Initiatives include: • Doctor's Office Quality–Information Technology (DOQ–IT) - Helps Oregon medical practices implement and optimize electronic health record systems • Culture and Medicine Project - helps providers recognize and respond to culture-based issues that affect communications with patients and their ability to follow a treatment plan • Performance improvement project training for managed mental health organizations • Rural Health Patient Safety Project	CMS Medicare contracts, state Medicaid contracts, project-base state and private funding	Providers, including nursing homes, hospitals, home health agencies, medical practices, Medicare Advantage plans, Part D Prescription drug plans
Advancing Excellence in America's Nursing Homes	National campaign initiated by CMS. Oregon's Local Area Network for Excellence (LANE) includes Acumentra Health, The Oregon Alliance of Senior and Health Services, the Oregon Health Care Association, the Hartford Center for Geriatric Nursing Excellence at OHSU's School of Nursing, the Oregon Pain Commission, the Oregon Patient Safety Commission and Seniors and People with Disabilities; Over 23 nursing homes in the state have registered	Voluntary campaign aimed at improving quality of care in nursing homes. Oregon's LANE focusing on reducing high risk pressure ulcers, improving pain management for longer-term and post-acute nursing home residents, assessing resident and family satisfaction with quality of care and staff retention.	Support from LANE network	Providers -Nursing homes

Compare Hospital Costs Web Site	Joint effort of Department of Consumer and Business Services (DCBS) and OHPR	DCBS requires insurers in Oregon to report on payments made to Oregon hospitals. OHPR makes information on the average payments for inpatient claims for patients in Oregon acute-care hospitals available on a public website. The Website contains data on the average payments for 82 common conditions or procedures.	DCBS and OHPR agency budgets	Consumers and Researchers
Department of Human Services (DHS)	State agency made up of five divisions: Children, Adults and Families Division, Addictions and Mental Health Division, Public Health Division, Division of Medical Assistance Programs, and Seniors and People with Disabilities Division.	• Public health chronic disease department has convened plan and provider quality groups to develop a common approach to population-based guidelines including diabetes, asthma and tobacco prevention. • Heart, stroke, diabetes, asthma, and tobacco-use prevention associations and DHS all have educational and collaborative programs that encourage compliance with evidence-based guidelines. • Division of Medical Assistance Programs measures, reports and assists with quality improvement through its Quality Improvement Project • Office of Health Systems Planning and Public Health Division have a patient safety policy lead dedicated to providing leadership, information and skills, support and resources to health care providers and patients so that they can ensure patient safety	Agency budget	Providers
HB 2213 (2007) - Health Insurance Cost Transparency Bill	Department of Consumer and Business Services	Effective July 1, 2009 insurers will be required to provide a reasonable estimate (via an interactive Web site and toll-free telephone) of an enrollee's cost for a procedure before services are incurred for both in-network and out-of-network services.	Requirement of health plans to provide service to enrollees	Consumers, Health Plans, Providers

Oregon Association of Hospitals and Health Systems (OAHHS)	Oregon Association of Hospitals and Health Systems is a statewide health care trade association representing hospitals and health systems	• Posts comparative information about hospital performance on quality indicators on OAHHS website • Supports website, www.orpricepoint.org, that provides comparative charge information for Oregon hospitals • Implementing colored coded wrist band system in Oregon hospitals to improve patient safety • Convenes multi-stakeholder group to define common measures and common expectations of hospital quality ▪ Co-founder, with OMA of Oregon Quality Community	OAHHS budget largely supported through member dues	Consumers, Hospitals and Health Systems
Oregon Chapter of the American College of Surgeons (ACS)	State chapter of ACS, a professional association established to improve the care of the surgical patient by setting high standards for surgical education and practice	Championing National Surgical Quality Improvement Program (NSQIP) in Oregon hospitals • NSQIP collects data on 135 variables, including preoperative risk factors, intraoperative variables, and 30-day postoperative mortality and morbidity outcomes for patients undergoing major surgical procedures in both the inpatient and outpatient setting • ACS provides participating hospitals with tools and reports needed to compare its performance with performance of other hospitals and develop performance improvement initiatives • Started the NSQIP Consortium to identify, implement, and disseminate best practices using clinical evidence sharing aggregate data with Consortium hospitals and educating the community about NSQIP. Currently includes 5 hospitals in Portland and 1 in Eugene with hope to expand statewide	Participating hospitals (currently four in Oregon, soon expanding to 6) pay fee for participating in NSQIP; American College of Surgeons	Providers - Hospitals and Surgeons
Oregon Coalition of Health Care Purchasers (OCHCP)	Non-profit organization of private and public purchasers of group health care benefits in Oregon or Southwest Washington	Uses the joint purchasing power of the public and private membership to improve health care quality across the state and give employers the tools they need to purchase benefits for their employees based on quality. In 2007, the OCHCP started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. In 2007, results were shared only with OCHCP members but may be released to larger audience in future.	Member dues, corporate sponsors	Purchasers, Health Plans, Providers
Oregon Community Health Information Network (OCHIN)	Not-for-profit organization that supports safety-net clinics; collaborative of 21 members serving rural and urban populations of uninsured or under-insured	• Using collaborative purchasing power to make health information technology products more affordable to safety net clinics • Offers consulting services, technical services to help staff in member clinics more effectively use health information technology to improve quality	Current funding from HRSA and AHRQ, Cisco Systems, Inc., State of Oregon, PSU and Kaiser	Providers - Clinics serving vulnerable populations

Oregon Health and Sciences University Medical Informatics	Partnership with American Medical Informatics Association, which started a 10 x 10 initiative to get 10,000 health care professionals trained in health care informatics by 2010	Offers a 10x10 certificate program which helps health care providers get training in medical informatics, the use of information technology to improve the quality, safety, and cost-effectiveness of health care	Student fees	Providers - Current and future health care providers
Oregon Health Care Quality Corporation	Multi-stakeholder non-profit organization; Collaboration of health plans, physician groups, hospitals, public sector health care representatives, public and private purchasers, health care providers, consumers and others with a commitment to improving the quality of health care in Oregon	• Aligning Forces for Quality - building community capacity to use market forces to drive and sustain quality improvement by:(1) Providing physicians with technical assistance and support to help them build their capacity to report quality measures and use data to drive quality improvement (2) Working with providers and other stakeholders to provide consumers with meaningful clinic-level comparisons of primary care quality, which includes identifying a common set of quality measures for the state(3) Educating consumers about the importance of using quality information to make health care decisions and building a consumer-friendly website to provide quality information and self-management resources • Developing private and secure health information technology systems that allow individuals and their providers to access health information when and where they are needed	Robert Wood Johnson Foundation supporting Aligning Forces grant; Health Insurers, PEBB, OCHCP also providing funding for efforts to make quality info available to customers	Consumers, Providers, Purchasers

Oregon Health Policy Commission (OHPC)	The OHPC was created by statute in 2003 to develop and oversee health policy and planning for the state. The Commission is comprised of ten voting members appointed by the Governor, representing all of the state's congressional districts and including four legislators (one representing each legislative caucus) who serve as non-voting advisory members.	OHPC has a Quality and Transparency Workgroup which is working towards making meaningful health care cost and quality information available to inform providers, purchasers and consumers.	OHPC Budget	Consumers, Providers, Purchasers, Consumers
Oregon Hospital Quality Indicators	Joint effort of Office for Oregon Health Policy and Research (OHPR) and Oregon Health Policy Commission (OHPC) with input from various stakeholders	Produces annual web-based report on death rates in hospitals for selected procedures and medical conditions	OHPR agency budget	Consumers, Purchasers
Oregon IHI 5 Million Lives Network	Joint effort of Oregon Association of Hospitals and Health Systems, Oregon Patient Safety Commission, Oregon Medical Association, Acumentra, Oregon Nurses Association, CareOregon; leading statewide expansion of Institute for Healthcare Improvement 10,000 Lives Campaign	6 statewide organizations working together to champion the use of 12 evidence-based best practices in over 40 hospitals across Oregon	Funding from six sponsor organizations	Providers – Hospitals

Oregon Patient Safety Commission	Created by the Oregon Legislature in July 2003 as a "semi-independent state agency." Board of Directors appointed by Governor and approved by Senate, to reflect the diversity of facilities, providers, insurers, purchasers and consumers that are involved in patient safety.	• Developing confidential, voluntary serious adverse event reporting systems for hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers and outpatient real dialysis facilities in Oregon with main goal of providing system level information • Using information collected through reporting to build consensus around quality improvement techniques to reduce system errors • Developing evidence-based prevention practices to improve patient outcomes information from hospitals on adverse events and reports to public	Fees on eligible hospitals, nursing homes, ambulatory surgery centers, retail pharmacies, birthing centers, outpatient renal dialysis facilities; Grants	Providers including hospitals, nursing homes, ambulatory surgery centers and retail pharmacies, Consumers
Oregon Primary Care Association	A nonprofit member association representing federally qualified health centers (FQHC)	Provides quality improvement technical assistance to its FQHC members, who also participate in Bureau of Primary Care learning collaborative	OPCA budget, funded primarily through membership fees	Providers serving vulnerable populations
Oregon Quality Community	Joint effort of Oregon Association of Hospitals and Health Systems and Oregon Medical Association; Steering Committee comprised of hospital and health system representatives	• Working with hospitals across the state to improve patient safety through improved hand hygiene. • Medication reconciliation project in planning stages.	OAHHS and OMA funding	Providers – Hospitals
Patient Safety Alliance	Partnership of Acumentra Health, Oregon Chapter of the American College of Physicians, Oregon Chapter of the American Collage of Surgeons, Northwest Physicians Insurance Company, Oregon Academy of Family Physicians and Oregon Chapter of the Society of Hospital Medicine	• Building multidisciplinary teams, including senior leadership, at Oregon hospitals to identify quality problems and build skills and models to be used for hospital-based process and quality improvement activities. Ultimate goal is to improve performance on CMS/Joint Commission medical care and surgical care measures.	Funding from six sponsor organizations	Providers – Hospitals

Public Employees Benefits Board	PEBB currently contracts with Kaiser, Regence, Samaritan and Providence to provide health care benefits to state employees	• With implementation of PEBB Vision for 2007, PEBB makes contracting decisions based on value and quality of care provided through health plans. Plans who contract with PEBB must agree to make an ongoing commitment to implement specific quality improvement initiatives, including requiring participating hospitals to report annual performance measures and national and local level quality indicators (i.e. the Leapfrog survey, Oregon Patient Safety Commission, HCAHPS survey), and developing long-term plans to implement information technology that will improve quality of care. • PEBB Council of Innovators brings the medical directors and administrative leaders from the four plans with contracts together to identify and share best practices.	State funds used to purchase employee benefits	Consumers, Health Plans, Providers
Regence Blue Cross Blue Shield	Not-for-profit health plan	Provides feedback on 40+ indicators of quality evidence based care to patients to nearly 40% of clinicians. This Clinical Performance Program includes patient specific data to allow correction and support improvement.	Regence budget	Providers
The Foundation for Medical Excellence	Public non-profit foundation, whose mission is to promote quality healthcare and sound health policy	Promoting quality healthcare through collaboration, education and leadership training opportunities for physicians	Support from individuals, foundations, health care organizations, consumer advocates and other Oregon businesses	Providers

The Health Care Acquired Infection Advisory Committee	Statutorily mandated committee comprised of seven health care providers with expertise in infection control and quality and nine other members who represent consumers, labor, academic researchers, health care purchasers, business, health insurers, the Department of Human Services, the Oregon Patient Safety Commission and the state epidemiologist.	Advising the Office for Oregon Health Policy on developing a mandatory reporting program for health care acquired infections to start in January 2009 for subsequent public reporting.	Additional appropriations made to OHPR in 2007 Legislative Session	Consumers, Providers

Other Initiatives

- The newly formed Oregon Educators Benefits Board is currently determining how to build quality improvement requirements into contracts with health plans
- Independent Practice Associations and Medical Groups are investing millions of dollars to assist their clinicians in implementing electronic health records, registries and other electronic support resources to measure and improve quality

Appendix B: Select State Quality Improvement and Transparency Efforts

This document does not provide a comprehensive description of all quality improvement across the country. Rather, it is meant to provide descriptions of some of the most innovative and influential activities in select states.

Maine

Maine Quality Forum **(MQF)** – an independent division of Dirigo Health (a broad strategy to improve Maine's health care system by expanding access to coverage, improving systems to control health care costs and ensuring the highest quality of care statewide) created by the Legislature and Governor in 2003

- Governed by a Board chaired by surgeon and includes members representing government agencies and labor, as well as an attorney. The Maine Quality Forum Advisory Council (MQF-AC) is a multi-stakeholder group consisting of consumers, providers, payers and insurers that advises the MQF.
- Consumer-focused organization established to provide reliable, unbiased information, user-friendly information to consumers. Website serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers
- Website provides data charts comparing geographical variation in chronic disease prevalence and number of surgeries performed for various conditions, as well as information about quality of hospital care reported by hospital peer groups
- Key tasks:
    - Assess medical technology needs throughout the state and inform the Certificate of Need process
    - Collect research on health care quality, evidence based medicine and patient safety
    - Promote the use of best medical practices
    - Coordinate efficient collection of health care data – data to be used to assess the health care environment and facilitate quality improvement and consumer choice
    - Promote healthy lifestyles
    - Promote safe and efficient care through use of electronic administration and data reporting

Maine Health Care Claims Data Bank **–** nation's first comprehensive statewide database of all medical, pharmacy and dental insurance claims, as well as estimated payments made by individuals (including co-pays, deductibles and co-insurance)

- Public-private partnership between ***Maine Health Data Organization*** and ***Maine Health Information Center*** – jointly created ***Maine Health Processing Center*** in 2001
    - Maine Health Data Organization (MHDO) - created by the state Legislature in 1996 as an independent executive agency (see below for more information)
    - Maine Health Information Center - independent, nonprofit, health data organization focused on providing healthcare data services to a wide range of clients in Maine and other states
- Beginning in January 2003, every health insurer and third party administrator that pays claims for Maine residents required to submit a copy of all paid claims to the MHDO. Maine Health Processing Center serves as technical arm and has built and maintains the data bank, collects claims information and submits a complete dataset

to MHCO. Database now includes claims from MaineCare (Medicaid) and Medicare.
- New Hampshire, Massachusetts and Vermont are all working with Maine (through contracts with either Maine Health Processing Center or Maine Health Information Center) to develop or modify claims databases so that all states collect same information, use same encryption codes, etc.

Maine Health Data Organization ***(MHDO)-*** independent executive agency created by state legislature to collect clinical and financial health care information to exercise responsible stewardship in making information available to public
- Maintains databases on: hospital discharge inpatient data, hospital outpatient data, hospital emergency department data, hospital and non-hospital ambulatory services as well as complete database of medical, dental and pharmacy claims (see above).
- Makes rules for appropriate release (for fee) of information to interested parties. Recent rule changes allows for release of information that identifies practitioners by name (except Medicare data).
- Directed by Maine Quality Forum to collect certain data sets of quality information – currently collecting information on care transition measures (CTM-3), Healthcare Associated Infections and Nursing Sensitive Indicators.
- Currently developing database of price information

Maine Health Management Coalition - coalition of employers, doctors, health plans and hospitals working to improve the safety and quality of Maine health care
- Goals: collect accurate, reliable data to measure how Maine is doing, evaluate data to assign quality ratings, present data in a way that is easy to understand and use
- Website provides individual primary care doctor quality ratings based on use of clinical information systems, results of diabetes care, and results of care for health disease. Blue ribbon distinction given to highest performers.
- Website provides hospital quality rankings based on patient satisfaction, patient safety, and quality of care for heart attack, heart failure, pneumonia, and surgical infection
- Established Pathways to Excellence programs to provide employees with comparative data about the quality of primary care and hospital care and reward providers (financially and through recognition) for quality improvement efforts. Plans to expand to specialty care.

Quality Counts **–** regional health care collaborative with range of stakeholder members including providers, employers and purchasers, state agencies
- Initiated as effort to educate providers about the Chronic Care Model
- Funded by membership contributions, as well as funding from Robert Wood Johnson Foundation
- Grantee of Robert Wood Johnson Aligning Forces for Quality - collaborating with other quality improvement organizations in the state on Aligning Forces goals:
    - Help providers improve their own ability to deliver quality care.
    - Help providers measure and publicly report their performance.
    - Help patients and consumers understand their vital role in recognizing and demanding high-quality care
- Contract from Maine Quality Forum to create a learning collaborative for stakeholders involved in quality improvement

Massachusetts

Massachusetts Health Quality Partners ***(MHQP)*** - broad-based independent coalition of physicians, hospitals, health plans, purchasers, consumers, and government agencies working together to promote improvement in quality and health care services in MA

- Members include: Blue Cross Blue Shield of Massachusetts, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Tufts Health Plan, Massachusetts Hospital Association, Massachusetts Medical Society, Massachusetts Executive Office of Health and Human Services, MHQP Physician Council, two consumer representatives, CMS Regional Office, and one employer representative.
- 5 strategic areas of focus:
    - Taking leadership role in building collaboration and consensus around a common quality agenda
    - Aggregating and disseminating comparable performance data
    - Increasing coordination and reducing inefficiencies to improve quality of care delivery
    - Developing and disseminating guidelines and quality improvement tools
    - Educating providers and consumers in the use of information to support quality improvement
- The MHQP web site compares performance of providers, reported at the group level, against state and national benchmarks on select HEDIS measures. Started with a focus on quality measurement for primary care providers and now expanded to include specialists and resource use measurements.
- MHQP website also allows the public to compare results of patient satisfaction surveys across doctors' offices.
- Convenes multi-disciplinary groups to work collaboratively to develop and endorse a single set of recommendations and quality tools for MA clinicians in order to streamline adherence to high quality, evidence-based decision making and care. Guidelines have been developed in the areas of Adult Preventative Care and Immunization, Pediatric Preventative Care and Immunization, Perinatal Care, Massachusetts Pediatric Asthma and Adult Asthma. MassHealth promotes use of guidelines for treatment of all enrollees.

Massachusetts Health Care Quality and Cost Council – a council of diverse stakeholder representatives established under recent statewide reform charged with setting statewide goals and coordinating improvement strategies.

- Established within, but not subject to the control of the Massachusetts Executive Office of Health and Human Services. Receives input and advise from an Advisory Committee that includes representation from consumers, business, labor, health care providers, and health plans.
- Charged assigned to the Council by the reform legislation include:
    - To establish statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities in health care
        - Vision established by the Council: By June 30, 2012, Massachusetts will consistently rank in national measures as the state achieving the highest levels of performance in case that is safe, effective, patient-centered, timely, efficient, equitable, integrated, and affordable.

        - Specific cost and quality goals for 2008 established in areas of cost containment, patient safety and effectiveness, improved screening for chronic disease management, reducing disparities, and promoting quality improvement through transparency.
    - To demonstrate progress toward achieving those goals
        - Council mandated to report annually to the legislature on its progress in achieving the goals of improving quality and containing or reducing health care costs, and promulgates additional rules and regulations to promote its quality improvement and cost containment goals
    - To disseminate, through a consumer-friendly website and other media, comparative health care cost, quality, and related information for consumers, health care providers, health plans, employers, policy-makers, and the general public.
        - Website publishes information about cost and quality of care listed by medical topic. Depending on condition or procedure, quality information is reported by provider and/or hospital and provides information about mortality (death) rates, volume and utilization rates and whether appropriate care guidelines are followed.

Minnesota

Buyers Health Care Action Group ***(BHCAG) –*** coalition of private and public employers working to redirect the health care system to focus on a collective goal of optimal health and total value

- Founding member of the **Leapfrog Group,** a national organization of private and public employers and purchasing coalitions who reinforce "big leaps" in health care safety, quality and customer value - "leaps" that can prevent avoidable medical errors. The Leapfrog Group's online reports allows consumers and purchasers of health care can track the progress hospitals are making in implementing four specific patient safety practices proven to save lives and prevent some of the most common medical mistakes
- One of eight organizations who joined together to develop the **eValue8™** Request for Information tool - a set of common quality performance expectations for health plans that purchasers can use to evaluate plans based on the value of care delivered. eValue8 collects information on plan profile, consumer engagement, disease management, prevention and health promotion, provider measurements, chronic disease management, pharmacy management and behavioral health. BHCAG, on behalf of the Smart Buy Alliance and its members, conducts a rigorous annual evaluation of major Minnesota health plans using eValue8 and makes results available to the public in an annual report (see **Minnesota Purchasers Health Plan Evaluation** below for more information)
- In 2004, introduced Bridges to Excellence (BTE), an employer directed pay-for-performance initiative that pays doctors cash bonuses for providing optimal care to patients with chronic diseases. BHCAG initiated a collaborative community plan to implement BTE, which includes 12 Minnesota private employers and public

purchasers (including Minnesota Department of Human Services) that have signed on as "Champions of Change" for a diabetes rewards program. Champions reward medical groups and clinics that provide high quality diabetes care. In 2007, BHCAG added a reward program for optimal coronary artery disease and is considering adding rewards for optimal care in depression and radiology.

Minnesota Smart Buy Alliance – voluntary health care purchasing alliance formed in 2004 by the State of Minnesota, business and labor groups to pursue common market-based purchasing principles.

- Alliance set up as a "Coalition of Coalitions" – Original members included The State of Minnesota Department of Employee Relations (purchaser of state employees benefits), Minnesota Department of Human Services (Medicaid, SCHIP, and MinnesotaCare), Buyer's Health Care Action Group (large private and public employers) Labor/Management Health Care Coalition of the Upper Midwest (union and management groups), Minnesota Business Partnership (large employers) Minnesota Chamber of Commerce (primarily small to mid-size employers) Minnesota Association of Professional Employees, Employers Association and CEO Roundtable. Original co-chairs were the leaders of three core member groups: the Department of Human Services, BHCAG, and the Labor/Management Health Care Coalition. The Labor/Management Health Care Coalition withdrew from the Alliance in 2007.
- Together, members of the Alliance buy insurance for more than 60% of Minnesota residents (3.5 million people).
- Alliance work is guided by four main principles:
  - Adopting uniform measures of quality and results
  - Rewarding "best in class" certification
  - Empowering consumers with easy access to information
  - Requiring health care providers to use the latest information technology for purposes of greater administrative efficiency, quality improvement and protecting patient's safety

QCare – Created by the Governor of Minnesota by executive order in July 2006 to accelerate state health care spending based on provider performance and outcomes using a set of common performance measures and public reporting

- All contracts for MinnesotaCare, Medicaid and Minnesota Advantage will include incentives and requirements for reporting of costs and quality, meeting targets, attaining improvements in key areas, maintaining overall accountability
- Initial focus in four areas: diabetes, hospital stays, preventative care, cardiac care
- Private health care purchasers and providers are encouraged to adopt QCare through the Smart Buy Alliance

The Institute for Clinical Systems Improvement (ICSI) – An independent, non-profit organization that facilitates collaboration on health care quality improvement by medical groups, hospitals and health plans that provide health care services to people in Minnesota.

- 62 medical groups and hospital systems are currently members of ICSI, representing more than 7,600 physicians.
- Funding is provided by all six Minnesota health plans

- Produces evidence-based best practice guidelines, protocols, and order sets which are recognized as the standard of care in Minnesota
- Facilitates "action group" collaboratives that bring together medical groups and hospitals to share strategies and best practices to accelerate their quality improvement work.

Governor's Health Cabinet - comprised of members of Governor's Administration and representatives from business and labor groups

- Created minnesotahealthinfo.org, a clearinghouse website designed to offer a wide range of information about the cost and quality of health care in Minnesota. The site is now maintained by the Minnesota Department of Health and provides links to organizations that provide cost and quality information about Minnesota providers, as well as information about buying health care, managing health care conditions and staying healthy. The site provides links to the following state-based quality and cost public reports (links to national efforts, such as AHRQ, CMS, Leapfrog Hospital Survey Results, NCQA, are also provided):
    - **MN Community Measurement™** - a non-profit organization that publicly reports health performance at the provider group and clinic level. MN Community Measurement recently launched D5.org, a website that specifically focuses on providing information about quality of diabetes care at clinics around the state.
    - Private insurance companies, including **HealthPartners**, **Medica** and **Blue Cross and Blue Shield of Minnesota** provide members and the public with information about provider quality and costs, as well as information about costs associated with individual procedures or total cost of treating certain conditions.
    - **Patient Choice Care System Comparison Guide** –consumer guide to care system quality, cost and service published on the web by Medica that allows consumers to compare provider organizations on factors such as their management of certain conditions, patient satisfaction, cost and special programs and capabilities.
    - **Minnesota Hospital Price Check** – web site sponsored by the Minnesota Hospital Association as the result of 2005 legislation that provides hospital charges for the 50 most common inpatient hospitalizations and the 25 most common same-day procedures.
    - **Minnesota Hospital Quality Report** – web site sponsored by the Minnesota Hospital Association and Stratis Health that provides easy access to quality measures for heart attack, heart failure, and pneumonia care at Minnesota hospitals.
    - **Healthcare Facts®** - site supported by Blue Cross Blue Shield of Minnesota that provides easy-to-read information on costs, safety and quality, and service information for large hospitals in Minnesota.
    - **Health Facility Investigation Reports** – web site supported by the Minnesota Department of health that allows the public to access complaint histories and investigation reports for a variety of Minnesota health care providers. The list includes nursing homes, board and care homes, home care providers, home health agencies, hospice facilities and services, hospitals, facilities that offer housing with services, and supervised living facilities. Searches can be done

for complaint information by date, provider type, provider name, and the county or city where the provider is located.

- **Adverse Health Events in Minnesota** – web-accessible reports, administered by the Minnesota Department of Health, on preventable adverse events in Minnesota hospitals (more information provided below).
- **Minnesota Purchasers Health Plan Evaluation** – web-accessible report, prepared by the Buyers Health Care Action Group (BHCAG), compares health plan performance in the following areas: health information technology, consumer engagement and support, provider measurement, primary prevention and health promotion, chronic disease management, behavioral health, and pharmacy management based on eValue8 survey results.
- **Minnesota's HMO Performance Measures** – site supported by Minnesota Department of Health's Manage Care Systems section links consumers to quality of care information reported by Minnesota HMOs on common health care services for diabetes, cancer screenings, immunizations, well-child visits, and high blood pressure.
- **Minnesota Nursing Home Report Card** – an interactive report card from the Minnesota Department of Health and the Department of Human Services allows the public to search by geographic location and rank the importance of several measures on resident satisfaction, nursing home staff and quality of care.
- **Minnesota RxPrice Compare** - web site displays local pharmacy prices for brand name, generic equivalent and therapeutic alternative medication options. The consumer tool compares the "usual and customary" prices of 400 commonly used prescription medications. Some of the brand name medications on this site include a list of generic medications that may be cost effective alternatives to the more expensive brand name medication. The site provides information about accessing lower-cost prescription medicine from Canada.

Adverse Health Care Events Reporting System **–** established in 2003 in response to 2003 state legislation requiring hospitals, ambulatory surgical centers and regional treatment centers to report whenever one of 27 "never events" occurs

- Website maintained by the Department of Health allows public to access annual report of adverse events and search for adverse events at specific hospitals. The report must also include an analysis of the events, the corrections implemented by facilities and recommendations for improvement.
- In September, 2007, the Governor of Minnesota announced a statewide policy, created by the Minnesota Hospital Association and Minnesota Council of Health Plans and endorsed by the Governor's Health Care Cabinet, which prohibits hospitals from billing insurance companies and others for care associated with an adverse health event.

Pennsylvania

Pennsylvania Health Care Cost Containment Council ***(PH4C)*** - independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access for all citizens regardless of ability to pay.

- Funded through the Pennsylvania state budget and sale of datasets
- Includes labor and business representatives and health care providers
- Seeks to contain costs and improve health care quality by stimulating competition in the health care market by giving comparatives information about the most efficient and effective providers to consumers and purchasers
- Hospitals and ambulatory surgery centers are mandated to provide PH4C with charge and treatment information. PH4C also collects information from HMOs on voluntary basis.
- Produces free comparative public reports on hospital quality and average charge. Reports on diagnosis include number of cases, mortality rating (ratings reported as significantly higher than expected, expected or significantly lower than expected), average length of stay, length of stay for short and long stay outliers, readmission ratings for any reason and for complication and infection, and average charge. Reports on specific procedures include number of cases, mortality rating, length of stay, readmission ratings and average charge.
- HMO quality reports also available on website. Interactive website tool allows consumers to find comparative information about plan profiles, plan ratings (based on utilization data and clinical outcomes data), plan performance on preventative measures, and member satisfaction.
- Website also provides reports on utilization by county, quality of heart bypass and hip and knee replacement reported by hospital and surgeon, and hospital financials. In addition, an interactive hospital inquired infection database can be searched by hospital, by infection, and by peer group.

Washington

Puget Sounds Health Alliance – Regional partnership involving more than 150 participating organizations, including employers, public purchasers, every health plan in the state, physicians, hospitals, community groups, and individual consumers across five counties

- Financed through county and state funding, as well as member fees - participating health plans pay a tiered fee based on their market share; providers pay according to their number of full-time employees; and purchasers and community groups pay a fee for each "covered life"—the number of employees and their families receiving employer-based health benefits. Individual consumers can join the alliance for $25 per year.
- Plans to release region's first public report on quality, value and patient experience at the end of January 2008
    - The first report will compare performance on aspects of care provided in doctors offices or clinics, using measures that reflect best-practices particularly for people with chronic conditions such as diabetes, heart disease, back pain and depression – a first draft of the report has been posted on the Alliance website for public comment

    - Future plans to expand report to include results for all doctors' offices and clinics over a certain size in the five-county region. Future reports will also compare hospital care and efficiency.
- Convenes expert clinical improvement teams to: identify and recommend evidence-based guidelines for use by physicians and other health professionals; choose measures that will be used to rate the performance of medical practices and hospitals regarding care they provide; and identify specific strategies that will help improve the quality of care and the health and long-term wellbeing for people in the Puget Sound region
    - Clinical improvement reports have been released on heart disease, diabetes, prescription drugs, depression and low back pain. Teams currently developing asthma and prevention reports.

Wisconsin

Wisconsin Department of Employee Trust Funds - purchases health care for more state and local employees, retirees and their dependents, making it the largest purchaser of employer coverage in the state.

- Publishes "It's Your Choice" guide in print and on website intended to assist state employees in choosing health plan based on quality. The 2007 guide provides information about how many of a health plan's network hospitals have: submitted data to Leapfrog; fully implemented or made good progress on implementing patient safety measures endorsed by the National Quality Forum; provided data for prior year's error prevention measures and clinical measures reported through CheckPoint (see below); and provided data on Medication Reconciliation through CheckPoint. The guide also reports health plan quality improvement efforts, whether the plan has a 24-hour nurse line or an electronic diabetes registry, and responsiveness to enrollee calls.
- Health plans are assigned to one of three tiers, based on cost and quality and member premium contributions vary by tier. Tier designation originally based mainly on cost, but more emphasis has been put on quality by incorporating scores on patient safety, customer satisfaction, diabetes and hypertension care management, and rates of childhood immunizations and cancer screenings.
- "Quality Composite System" provides enhanced premiums to health plans displaying favorable patient safety and quality measures.

Wisconsin Hospital Association CheckPoint and Price Point – comparative web-based reports on hospital cost and quality based on data voluntarily reported by hospitals

- Check Point - provides comparative reports of hospital performance. Reports can be created to compare hospital performance on 14 interventions for heart attacks, heart failure, and pneumonia, 8 surgical service measures, and 5 error prevention goals.
    - Prevention measures recently expanded to include medication reconciliation measure, which indicates hospital's progress toward identifying the most complete and accurate list of medications a patient is taking when admitted to the hospital and using that list to provide correct medication for patient anywhere within the health care system.
- Price Point - allows health care consumers to receive basic, facility-specific information about services and charges associated with inpatient and outpatient services

Wisconsin Health Information Organization (WHIO) - non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals,

- Building a statewide, centralized health repository based on voluntary reporting of private health insurance claims and pharmacy and lab data from health insurers, self-funded employers, health plans, Medicaid, and the employee trust fund
- Planning to use information to develop reports on the costs and quality of care in ambulatory settings.

Wisconsin Collaborative for Healthcare Quality ***(WCHQ) -*** voluntary consortium of organizations, including physician groups, hospitals, health plans, employers and labor organizations learning and working together to improve the quality and cost-effectiveness of healthcare for the people of Wisconsin

- Governed by an assembly, comprised of CEOs, CMOs and Senior Quality Executives from each of the member institutions; Board of directors comprised of CEOs (or designees) from each member organization plus two delegates from Business Partners; receives input from workgroup of experts and business partners and business coalitions
- Web-based public Performance and Progress Reports provide comparative information on its member physician practices, hospitals, and health plans. Interactive tool allows for searches by provider types and region, clinical topic or IOM quality category (safety, timeliness, effectiveness, patient-centeredness), as well as comparison against WQHC averages and national performance.
- Set goal for providers to score above JCAHO 90 percentile performance.
- Tools designed to allow members to report data through website
- http://www.wisconsinhealthreports.org - set up as single source of quality and cost data for Wisconsin and includes links to WQHC, as well as Price Point and Check Point

Appendix C: Quality Institute Budget

Assumptions

- The following budgets assume the Quality Institute will have an unpaid voluntary Board of Directors, and voluntary advisory committees as appointed by the Board. The budgets below will have to be adjusted if the state decides the Quality Institute should have a paid Board.
- The Quality Institute will pursue all of the priority roles established in the accompanying report. The budget of the Quality Institute will determine the Institute's ability to pursue a range of other functions.
- The budget allocation for strategic investments will be used to fund projects, in partnership with other quality improvement organization, that align with the mission of the Quality Institute. A significant amount of staff and Quality Institute Board member time will have to be dedicated to developing strategic alliances with other organizations and making transparent decisions about how these dollars can be used to maximize quality improvement across the health care system.

Annual Budget

Operations	
Personnel Costs (lead staff, data analyst, policy analyst, support staff)	$575,000
Software and Infrastructure	$30,000
Roles: Coordination and Collaboration and Policy Advising	
Meeting Costs	$50,000
Roles: Systematic Measurement of Quality	
Vendor Costs (data collection and reporting)	$900,000
Roles: Provider Improvement and Technical Assistance and Consumer Engagement	
Strategic Investments*	$750,000
Total	$2,305,000

The Quality Institute Work Group recommends that the state provide at least $4.6 million per biennium ($2.3 million annually) to establish and operate a Quality Institute able to significantly improve the quality and transparency of Oregon's health care system.

Reference Budgets Consulted
Population of Oregon: 3.7 million

Maine Quality Forum (See Appendix B for full description)

- Budget: MQF has an operating budget of $1 million annually, with administrative and staff salaries funded by the Dirigo Health Authority
- Population of Maine: 1.3 Million (2.4 million less than Oregon)
- Functions: MQF has convening and public reporting functions and advises state government on quality improvement issues. MQF does not directly collect data.

Utah Statewide All Claims Database (as proposed by Utah Department of Health)

- Budget: $1 million annually (includes software costs, vendor contract to clean, merge and maintain data securely and create public reports, one FTE to oversee and manage project and travel)
- Population : 2.6 Million (1.1 million less than Oregon)
- Functions: Create an all-claims database of all medical, pharmacy and dental claims processed for Utah residents and enrollment data for all health plan member. Create public cost and quality reports.

The Pennsylvania Health Care Cost Containment Council (PHC4)

- Budget: Approximately $5 million annually
- Population: 12.4 million (~3 times population of Oregon)
- Functions: Maintains a database of all hospital discharge and ambulatory/outpatient procedure records each year from hospitals and freestanding ambulatory surgery centers. Reports data about the cost and quality of health care to public. Studies quality and access issues. Advises state government on quality improvement issues.

Oregon patient safety Commission

April 15, 2008

Vickie Gates, Chair
Quality Institute Work Group
to the Delivery Systems Committee
Oregon Health Fund Board

Dear Vickie:

I'd like to offer a few words in support of the idea of a publicly-funded strategic investment in quality. As you know, the Patient Safety Commission is a quasi-state agency with the mission of reducing the risk of medical errors in Oregon. We work with hospitals, nursing homes, ambulatory surgery centers, retail pharmacies and others. Our funding comes from participation fees; we receive no public monies. Our model of governance (a multi-stakeholder board of directors appointed by the Governor) and our cooperative approach to quality improvement offer an intriguing mix; as a result the work group charged with drafting a proposal for a Quality Institute took a careful look.

That work group unanimously agreed that a new Quality Institute needs to be a 'lean' organization with the ability to make State-sponsored strategic investments in quality and patient safety. In order to illustrate the appeal of this approach, I would like to describe three on-going projects sponsored by the Patient Safety Commission that could benefit from such strategic investments:

North Star Goal – The Patient Safety Commission has challenged Oregon's entire healthcare system to become the "safest state in the country by 2010." Among other things this goal creates a way to align efforts. It also forces us to quickly develop a measurement scheme. And it helps set priorities. This is a goal that benefits all, yet can only succeed if the challenge is widely embraced. Such a project, I would argue, could justify and greatly benefit from a modest strategic investment. State dollars could help create and sustain the measurement tool (creating benchmarks, marking progress, developing national comparisons). State involvement could bring public purchasing power into alignment. State public health resources could help us develop a consumer engagement strategy.

Pressure Ulcer Transitional Care Project - Last summer the Patient Safety Commission and 10 other statewide groups sat down at the same table to discuss coordination of health care across organizational boundaries. This in itself was an important moment -- hospitals, nursing homes, state regulators, nurses, physicians, home

health agencies, along with quality improvement organizations, put aside any differences to talk about *transitional care*. By the end of the meeting all 11 groups had agreed to work together on a specific project – to eliminate or greatly reduce the risk of pressure ulcers as patients move from one healthcare setting to another.

This work is well underway. Last fall, the steering committee for the 11 groups interviewed 68 wound care and transitional care experts. In January and February 2008 the steering committee convened an expert panel to develop consensus standards for preventing and minimizing pressure ulcers across care settings in Oregon. The panel also defined a 'hand-off' data set that should be passed from one setting to another. The steering committee is now testing these transitional care tools in two community pilots (The Dalles, Lebanon). Next fall we hope to share summary findings with the entire state.

Extending NSQIP to rural hospitals – Seven hospitals in Oregon currently participate (or have indicated their intention of participating) in the National Surgical Quality Improvement Project. The intent of NSQIP is to create standardized, risk adjusted data on surgical complications in order to create new evidence-based practices. In essence, NSQIP hospitals represent a laboratory for the next generation of surgical improvement ideas. The Patient Safety Commission is partnering with these hospitals to act as a 'distribution channel' for these ideas. The Oregon NSQIP group is especially interested in finding ways to include rural hospitals in this program.

In brief summary, these three projects benefit everyone. Each project is bigger than any one organization; each has a clear public good. With a strategic investment of public funds we could move these (and similar) projects faster and further.

Sincerely,

Jim Dameron
Administrator

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OREGON HEALTH CARE QUALITY CORPORATION
A nonprofit partnership for quality improvement

April 15, 2008

Vickie Gates, Chair
Quality Institute Work Group
to the Delivery Systems Committee
Oregon Health Fund Board

Dear Vickie,

The Quality Institute report being sent to the Delivery System Committee for Senate Bill 329 recommends strategic State investments in collaborative quality efforts. This is a critical component of the recommendation. The Oregon Health Care Quality Corporation is eager to provide potential examples of such investments so that this recommendation becomes real to those making decisions.

As a leading organizer of private sector investments in collaboration for quality, the Quality Corp is keenly aware of opportunities for a state "boost". The Quality Corp brings together providers of care, purchasers, health plans and consumers to put the "system" in the health care sector. For the past four years we have helped the community achieve a vision for improved care quality through better measurement and through planning for secure exchange of health care information. With a 2008 budget of just over a million dollars, we have a demonstrated track record for organizing grant and private sector investments. The partners efforts could be considerably more effective with a significant and strategic state investment.

Attached are two ideas, which we hope stimulate support for the Quality Institute workgroup's recommendations. If we can supply additional ideas or information, please let us know when, where and how to help.

Sincerely,

Nancy Clarke
Executive Director

cc: Ralph Prows, MD, Chair, Quality Corporation
Ilana Weinbaum, Health Fund Board Policy Analyst

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Potential Strategic Investments of the Quality Institute

Project Name:

Finding and Spreading High Value Health Care through Episode Analysis

What the Project Accomplishes:

A current voluntary project pools data from 10 health plans to measure the quality of care in Oregon clinics. The project helps providers improve their care quality and helps consumers and purchasers use the information for seeking high value care. A strategic state investment would analyze the same all-payer data from an episode value perspective to guide policy development.

How State Investment Helps:

State investment will reduce the cost of liability insurance for the project and will purchase expert analysis of the data to understand variation in health care value. This expertise helps identify opportunities to address over and under-utilization in our delivery system.

How the Investment Furthers the Goals of SB329:

The state will capitalize on a private sector investment, and increase the ability to assess the effectiveness of how Oregon's accountable health system is or is not succeeding over time. By identifying where health care dollar investments are working, policy makers can more effectively direct their dollars.

Project Name:

Spreading innovations for nurse-led Quality improvement and reduced health care disparities in Oregon hospitals

What the Project Accomplishes:

As a member of the 14-community Aligning Forces for Quality Initiative, the Robert Wood Johnson Foundation is helping a few Oregon hospitals transform care at the bedside through nurse-led learning collaboratives. Additional collaboratives help selected hospitals identify and improve differences in care that may result from language, race and ethnicity factors. This project would spread these innovations to other hospitals.

How State Investment Helps:

State investment would assure that small and rural hospitals are able to participate in the innovative quality improvement as we move to spread these approaches to care.

How the Investment Furthers the Goals of SB329:

Evidence is emerging that better quality care costs less, and hospital expenditures are the largest component of the state's expenditures. A state investment in comprehensively improving the safety and quality of hospital care in our most challenged facilities is a wise long-term investment.

Oregon Health Fund Board
Delivery Systems Committee
Strawperson Decision Support Recommendations
DRAFT – FOR DISCUSSION ONLY 4/17/08

Recommendation 1: The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should develop or endorse standardized decision support processes for integrated health homes and other care settings, which account for patients' cultural, ethnic, racial and language needs. Decision support processes should identify opportunities for members of the care team and patients to discuss alternate treatments and patient preferences and should include the use of patient decision aids where appropriate. Initial efforts should be focused on developing shared decision making processes for patients with advanced chronic illness, who are hospitalized or have been recently hospitalized. These processes should aid patients in making decisions about goals of care and give them the opportunity to identify Physician Orders for Life-Sustaining Treatment (POLST) preferences.

Recommendation 2: Incentives and new payment codes should be used to encourage providers in state funded health programs to use decision making support processes and reimburse them for time spent engaged in tasks associated with these processes. Private purchasers and health plans should be encouraged to adopt the decision support processes.

Recommendation 3: The state should seek opportunities to partner with private stakeholders to develop and offer training courses to providers in facilitating shared decision making processes. Specific attention should be focused on training providers who work with patients with advanced chronic illness.

Recommendation 4: A statewide electronic POLST Registry should be created to ensure the availability of the POLST form at the time of need.

Oregon Health Fund Board
Delivery Systems Committee
Strawperson Payment Reform Recommendations
DRAFT – FOR DISCUSSION ONLY 4/17/08

Recommendation 1: The payment system should be reformed to move away from the fee-for service model to require health care providers to be accountable for quality, efficiency, care coordination and the total cost of care. A payment reform commission or committee should be established within the Oregon Health Fund Board, Quality Institute or another state agency, to develop specific recommendations for comprehensive payment reform guided by Recommendations 2-5 below.

Recommendation 2: The payment reform commission or committee (Commission) should establish a mechanism to increase the public transparency of prices for health care services. In doing so, the Commission should evaluate the feasibility and expected impact of a policy that would require all hospitals and health care professionals to establish a single price for each service or bundle of services they provide. This price would apply to all private and commercial purchasers. The price charged for a service or bundle of services would be the same for all private payers to reduce the administrative burden associated with negotiations between health plans and providers. These prices would be made publicly available through a state website, each third party payer and from providers. If such policies were implemented, it would be necessary to develop mechanisms to encourage efficiency, value and competition between providers based on price.

Recommendation 3: The current fee-for-service payment system undervalues primary care, care management and other cognitive services and the base fee level for these services should be increased, in a cost-neutral way. As the budget allows, there should be additional increases to the base fee level for services provided by primary care and other providers taking significant steps toward transforming into integrated health homes to account for the infrastructure required to make this transition. Expanded fee-for-service payments should be established for related services including, but not limited to:

- Telephone and email communication
- Pharmacist medication management
- Behavioral health counseling for chronic medical condition
- Palliative care services
- Conversations between care team member and patient about their goals of care and POLST preferences (for patients with advanced chronic disease)

Recommendation 4: Comprehensive payment reform should occur in three stages, with the eventual goal of all providers in the state moving to Level 3 by 2015 (?). All providers will participate in Level 1 and Level 3, with Level 2 focused on integrated health homes and other providers able to coordinate care across the care spectrum.

Level 1 Payment Reform – Quality and Efficiency
Providers meeting specific quality and efficiency targets or demonstrating significant improvement over time, will be eligible for quality/efficiency-based payments. Payments must be incorporated into existing payment systems in a budget neutral way. Initially, these payments should be based on process measures, with movement towards payments

based on outcomes measures. Quality and efficiency targets used to determine these payments should be established by the Oregon Quality Institute.

- Quality and efficiency targets for integrated health homes and other primary care providers should focus on preventative services and treatments of patients with the most prevalent chronic diseases.
- Payments to hospitals and specialists should also be adjusted for quality and efficiency performance.
- The process used to determine quality and efficiency payments must risk-adjusted.
- The Level 1 payment reform should be designed to reward providers for following evidence-based guidelines and to identify and reduce unwarranted practice variation among providers.
- The Level 1 payment reform process should be transparent and should make information about the quality and efficiency of providers available to the public.

Level 2 Payment Reform – Care Coordination Payments

Care coordination payments will be made available on a per-member per-month basis to providers who assume responsibility for coordinating their patient's care. Care coordination payments will be tied to the tiered integrated health home designation process (see integrated health home recommendations). Only providers and practices who are designated as integrated health homes will qualify for care coordination payments, with higher payments available for those designated as more advanced integrated health homes (higher tier of designation process). Providers and practices will also have to meet certain quality and efficiency targets established in Level 1 payment reform in order to quality for care coordination payments. Quality and efficiency payments will still be available to providers receiving care coordination payments.

- The amount of the care coordination payments should be adjusted for the complexity/risk of patients served (higher fees for patients with multiple chronic conditions).
- Funds made available for care coordination payments should first be directed at providers and practices able to effectively manage the care of patients with chronic disease.
- Care coordination payments should account for infrastructure costs associated with care coordination services.
- Care management fees should account for costs associated with care team discussions with patients about goals of care and Physician Orders for Life-Sustaining Treatment (POLST) preferences.
- Since care management fees will create additional payments to providers, Level 2 payment reform must be tied to an evaluation of whether better coordination leads to a decrease in the use of acute care services and overall cost savings.

Level 3 Payment Reform – Global Budgets
Providers and care systems will submit bids to health insurance plans, other health care purchasers, or consortiums of plans and purchasers, based on the total cost to provide care for an established population of patients. Global budgets will require providers and care systems to assume the responsibility for the total cost of care for a patient population, as well as the quality of care they provide. Providers will be required to meet Level 1 quality and efficiency targets to participate in Level 3 reform and quality and efficiency performance payments will still be available to providers operating on global budgets.

- Budgets must decrease cost over the current level of spending.
- Actual payments to providers should still be complexity/risk-adjusted to avoid penalizing providers who care for healthy and vulnerable populations.
- Global budgets could be based on the cost of providing just the "essential benefits package" or could include all patient care.
- Global budget bids should be reported publicly.
- The amount consumers pay for insurance (premium and/or out of pocket payments) could be dependent on the global budget of the provider they choose (lower for higher value provider).
- As part of Accountable Care District Authority Pilot Projects, opportunities for establishing global budgets for accountable care districts, rather than individual providers and care systems within a care district, should be explored.

Recommendation 5: In order to make it worthwhile for providers and care systems to participate in the new payment system and make it cost-effective for payers to change their payment policies, it is necessary that the majority of providers and payers participate in payment reform. The Commission will have to determine how payment reform will be staged among different segments of the population. Potential mechanisms for achieving majority participation include:

- Require all state funded health programs (OHF, OHFP, PEBB and OEBB) and all providers serving these patients to participate in payment reform
- Require participation by small group and individual markets
- Encourage voluntary (through incentives?) participation by other plans and providers.
- Others?

Oregon Health Fund Board
Delivery Systems Committee
Strawperson Public Health, Health Promotion and Wellness Recommendations
DRAFT FOR DISCUSSION ONLY - 4/17/08

Recommendation 1: The state should partner with public and private stakeholders, employers, schools and community organizations to establish priorities and develop aggressive goals for the prevention and reduction of health conditions and behaviors most detrimental to the health of Oregonians, particularly for obesity and tobacco use. The development of the priorities and goals should be aligned with efforts of the Quality Institute to improve the quality of care delivered to Oregonians.

Recommendation 2: The state should partner with local boards of health, providers, employers, schools, community organizations and other stakeholders to develop a statewide strategic plan for achieving these goals. As part of its strategic plan, the state should work with appropriate stakeholders to identify population-based health activities with evidence of improving health outcomes. This should be in collaboration with the efforts of the Quality Institute. The plan should seek to use existing resources more effectively before proposing actions that increase costs or require additional funding. Where it is clear that additional resources are essential in order to carry out the plan, such activities would be considered for funding as presented under Recommendation 3 below.

Recommendation 3: The state should establish and fund a Community-Centered Health Initiatives Fund (CHHI). This fund should be used to provide funding to develop and implement culturally and socially appropriate primary and secondary prevention activities in line with the goals and strategic plan discussed in Recommendations 1 and 2. These activities need to be aligned with the efforts of the Quality Institute to improve quality of care.

Activities funded by CHHI funds will meet the following criteria:

- Be based on community input;
- Be based on evidence and data;
- Will address behavior change a the individual, community and system levels;
- Coordinate efforts of local county health departments, community-based organizations, schools, employers and health care delivery system entities;
- Work to reduce health care disparities;
- Will be accountable for demonstrating measureable improvements in health status, health education and reduction of risk factors.

The funds would be directed to the following components:

Local Initiatives

- A portion of the CHHI will be used to fund activities delivered at the local level by county health departments, community-based organizations and health care delivery system entities. Collaborative coordinating councils (including local boards of health, community coalitions designed to increase access for vulnerable populations and/or improve quality of care, providers, employers, schools,

community organizations and others) should be established to develop and implement population health projects, building on existing efforts in the community.
    - Health care delivery system entities receiving Medicaid funding need to be a key aspect of these community efforts both locally and regionally, and must participate in the collaborative coordination councils.
    - Pilot payment reform and other efforts directed to particular accountable care health districts will need to be aligned with these local initiatives.

Regional Initiatives

- A portion of the CHHI will be used to fund regional efforts, particularly where local resources are insufficient to assure standards will be met.

State Initiatives

- A portion of the CHHI will be used to fund state government efforts to play a role in facilitating and coordinating local and regional prevention efforts. These funds will be used for standard setting, coordination, implementation assistance and evaluation in coordination. These activities will be coordinated with the Quality Institute's efforts. In addition, funds will be used to provide administrative support for local, regional and accountable care district initiatives, including:
    - Setting standards of performance for the state-set priority activities, and when appropriate, for other evidence-based prevention projects selected by communities.
    - Ensuring coordination of programs across jurisdiction, including the avoidance of duplicative services.
    - Providing technical assistance to counties, local communities, and delivery system entities to implement prevention projects.
    - Implementing a Prevention Projects Data System including the: development of standardized data elements; creation of data reporting mechanisms; compilation and analysis of data; and issuing an annual report detailing prevention activity performance.
- CHHI funds directed to state government will also be used to conduct state-level, evidence-based prevention and to develop and implement additional evidence-based prevention projects, aligned with the local and regional efforts, the Quality Institute, and other public or private efforts.

Recommendation 4: All state agencies, in partnership with PEBB, should develop a strategic plan for creating a culture of health for state employees. Workplace conditions across state agencies should encourage healthy behaviors, such as healthy eating and physical activity.

On the Importance of <u>Ethics</u>

To <u>Health</u> <u>Care</u> <u>Reform</u> in Oregon ...

" Something's Gotta Give":

Values and Ethics in Oregon's Health Care Reform

<u>Summary of the</u>

<u>18th Annual Kinsman Ethics Conference:</u>

Medford, Oregon

April 10-11, 2008

<u>Editor:</u>

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OVERVIEW: ***Why Health Care Reform? ... Why Ethics? ... Why Now?***

"Something's Gotta Give!" was the signature caption of the 18th annual Oregon Kinsman Medical Ethics Conference. This pithy phrase reflects the stark reality that just and humane health care reform will require *complex changes and difficult compromises*, some of which will be uncomfortable to many who have profited most from our current dysfunctional health care system. The ***inequalities of access to basic health care for over a third of our population*** *and* the ***meteoric rise of health care costs*** over the last three decades are simply ***not sustainable***, either morally or financially.

The OHSU Center for Ethics in Health Care and Continuing Medical Education of Southern Oregon co-sponsored this conference. This timely convening of Oregon's medical ethics leadership with key members of the Oregon Health Fund Board (OHFB) made explicit the fundamental values upon which to base health care reform in our state. James Sabin, M.D., Director of the Ethics Program at Harvard Pilgrim Health Care, and Barney Speight, Executive Director, State of Oregon Health Fund Board, catalyzed thoughtful exploration for the intense two day session.

In this paper we share the views of Oregon's medical ethics community, as a contribution both to the OHFB's transparent, democratic health care reform process … and to all those Oregonians who currently seek to create a healthier Oregon.

An Appendix containing all Kinsman Conference presentations, handouts and resource materials will be available to all conference participants and any other interested persons after May 1, 2008 from the OHSU Center for Ethics in Health Care (ethics@ohsu.edu).

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I. SUMMARY

The 18th annual Kinsman Conference held on April 10th and 11th was an intense interaction which created a wealth of worthy ideas for further consideration by all Oregonians. The conference focused specifically on the current health care reform deliberations by the Oregon Health Fund Board. The following are those ideas which had the most clear ethical agreement, historically strong societal support and potential for financial sustainability.

Universal Access: The need for universal access is essential, based on the ethical values of justice, stewardship, autonomy and compassion. Historically, there is strong societal support for such equal access to basic health care services. Hopefully, Oregonians will translate this support into near unanimous individual participation in the plan. An individual mandate for participation is necessary if the plan is to achieve financial sustainability. Adequate support for vulnerable persons will validate the compassion inherent in the health plan.

Rigorous Cost Management: No plan is sustainable unless the costs are affordable to Oregonians. The Healthy Oregon Plan must meet its obligation to operate within reasonable financial boundaries, thereby preserving state resources for other public services (e.g. education, transportation, safety). Rigorous management of costs will be absolutely necessary. This will require thoughtful assessment of which services to provide and how they should be delivered, yielding value through compromise ("Something's Gotta Give"). Rigorous cost management is strongly supported by the ethical values of justice and stewardship.

Prioritized Services: Oregonians accepted the relative value of health care services offered by the Oregon Health Plan. Likewise, in the proposed Healthy Oregon Plan, equitable distribution of resources requires acceptance of a finite global budget for health care services, necessitating a prioritized list, based on the relative cost-benefit of the service. Setting priorities supported by the ethical values of justice and compassion will be essential for financial sustainability.

Evidence-based services: Given finite resources, the Healthy Oregon Plan requires scientific evidence upon which to base decisions about the relative value of a specific service. This provides a rigorous and fair method for equitable and finite resource allocation, supported by the ethical values of justice and compassion.

Palliative and End-of-Life Care: There is clear ethical and societal support for access to high quality palliative and end-of-life care. Oregonians have a right to make their own health care decisions, especially in the final months of life. Current reimbursement structures and less than effective sharing of critical health information inhibit access to palliative care and time-intensive advance care planning. Improvements in access to palliative care will occur only if reimbursement that values these services is increased and by support for innovations such as a statewide electronic POLST registry.

Minimize Conflict of Interest: Conflicts of interest are inherent to any complex health care system. It is important that these conflicts be averted through divestment, or if unable, then through thoughtful management and transparency. Minimizing such conflicts is a goal of the ethical value of integrity, thus instilling trust into both the content and the process of the Healthy Oregon Plan.

II. THE IMPORTANCE OF ETHICS IN HEALTH CARE REFORM

Applying ethics to health care reform means putting our values into practice. Most of us agree that health is a central part of a good life. The ethical aim in health care is a good life for everyone through a fair health care system.

The values of compassion, stewardship, and justice are of greatest importance for achieving the ethical aims of health care. These are values that focus on *society*. On the other hand, autonomy and self-interest are values that focus on the *individual*. There must be a balance between interests of self and those of society. Thus, an individual must often give up some autonomy and self-interest to cooperate with society's values of compassion, stewardship and justice. In doing so, the interests of an individual serve the group and the interests of the group also serve individuals. At its center, health ethics is about compassion (relief of human suffering). Thus, achieving a reasonable, just and compassionate balance between conflicting interests is an important function of ethics.

III. THE PROCESS:

Ultimately, in the history of human societal change, it is the *process*, as much as the *content*, which determines success or failure. So it is for Oregon and health care reform at this critical moment. Responding directly to this challenge, this Kinsman Conference was most fortunate to have physician-ethicist Dr. James Sabin of Harvard as its mentor, integrating not only extensive expertise in helping health care communities set limits fairly, but also describing lessons to be learned from Massachusetts, where health care reform is well into its second year. Dr. Sabin described four elements necessary to forge an ethical and sustainable system:

- Limits must be *reasonable.*
- Debate and policies must be *public.*
- Policies must be *revisable.*
- Decisions, once made, must be *enforceable.*

He pointed out that the difficult issues of cost containment (e.g. global budgets) are as ethically valid (stewardship) as are the issues of justice (universal access). This conference included extensive input from several members of the Oregon Health Fund Board, the dynamic crucible of Oregon's health care reform, whose first six months of deliberation have seen a vigorous attempt to listen to Oregonians, gather information and consider possible solutions from both the *social* justice and the *market* justice perspectives. Soon, the dies must be cast. Forging a wise, fair and workable plan for Oregon will obviously require a healthy mixture of respectful confrontation and compassionate collaboration *if* a sustainable *balance* between *social justice* and *market justice* is to occur.

IV. UNIVERSAL ACCESS

Providing an easily accessible plan of basic medical services to every citizen of the state of Oregon was the central objective of Oregon Senate Bill 329. (This became one of the four primary goals of the Oregon Health Fund Board). This proposal epitomizes two of the most fundamental maxims of compassionate medical heritage: the prescription to *do the right thing for every patient* and *the duty to relieve human suffering* whenever possible. Universal access will also contribute significantly to 'the common good,' another important ethical tenet. Finally, this proposition is

socially just, providing many currently underserved Oregonians (about one-third of our population) the opportunity to participate more fully in the social and economic life of their families ... and their communities. Thus, the Kinsman Conference strongly endorsed *universal access as the most compelling and necessary component* of Oregon's health care reform.

V. IMPROVING *HEALTH* ... WITH LESS HEALTH CARE

Many problems in the current U.S. health system (high cost, inconsistent low quality) reflect the increasing disconnect between intensity of health *care* and actual *health* across the population. Substantial evidence suggests the following two interrelated pathways will be essential to any reconciliation effort planned as a part of health care reform:

- **Improving prevention and health-related behaviors**, means adapting proven "upstream" strategies (e.g., smoking cessation, reducing obesity) designed to modify the alarming and much more costly rise in "downstream" health crises. Such an effort will require shifting part of our health care budget away from acute health care and towards proven public health policies and preventive therapies. Ethically, this means "trading off" some of our traditionally prized American autonomy (individual choice) to obtain increased compassion (relief of human suffering and better health outcomes) for our population as a whole.

- **More attention to "the less well off":** Last fall, Steven Schroeder (NEJM 357:1226,2007) captured the essence of this:

  "... the biggest gains in population health will come from attention to the less well off ..."

  This more aggressive approach to currently underserved people will enhance earlier intervention, reduce emergency department use, reduce preventable hospitalization and decrease cost shifting. More importantly, it will improve the health and function of many Oregonians. Kinsman conference participants favored many specific strategies, the most prevalent being:

  - implementing universal access;
  - increasing access to behavioral health care;
  - expanding safety-net clinics and workforce;
  - strengthening primary care and its diverse workforce;
  - improving access to pediatric care;
  - expanding access to basic dental care;
  - protecting and enabling those with disabilities.

  Such strategies exemplify the practical application of the ethical duties of justice and compassion.

VI. IMPROVING THE SYSTEM

To achieve and maintain universal access will require:

- significant improvements in the efficiency of our health care system;
- strengthening primary care;
- rigorously addressing conflicts of interest and
- a realistic re-alignment of financial incentives.

Perverse incentives, inherent in the current system, lead to excess costs without meaningful improvement in the health of Oregonians. Addressing each of the examples below highlights an

ethically charged issue which, if successfully addressed, would improve the health care system, empower/respect patient choice and in most cases, reduce cost while improving quality.

1. **Electronic POLST registry** A person's wishes for medical treatments near the end-of-life can be effectively respected through Oregon's Physician Orders for Life-Sustaining Treatment (POLST) program. While health systems in Oregon generally do a better job of respecting patient wishes than those in most other states, a significant number of Oregonians with advanced illnesses (at or near end-of-life) continue to receive medical treatments that are not consistent with their wishes. Sometimes the POLST form with the person's medical orders can not be located in a time of crisis. Conference attendees strongly endorsed the creation of an electronic registry for POLST to assure that patient wishes to have or to limit medical treatments will be more consistently available to emergency medical professionals. Creation of a statewide electronic POLST registry is specifically recommended by Oregon Senate Bill 329 (the Healthy Oregon Act), the legislation that initiated Oregon health care reform.

2. **Strengthen primary care.** The recent substantial reduction in primary care professionals leaves many patients without a primary medical home. As a result, compassionate, coordinated, "whole person" care is reduced. Increasingly, inpatient care is provided by hospitalists and intensivists focusing treatment only on the acute medical problem(s) at hand.

To be sustainable, Oregon's new system must increase reimbursements/incentives to support more and better primary care including:

- Increased support for primary care workforce development: nurses and nurse practitioners, physician assistants, family practitioners, general internists, palliative care givers and geriatricians.
- Increased compensation for primary care professionals sufficient to enable provision of adequate primary care services to rapidly increasing numbers of patients.
- Development of a loan forgiveness program for those primary care professionals who plan to serve vulnerable populations.

3. **Strengthen palliative care** for inpatients with advanced chronic illnesses. Palliative care teams, when available, can help both improve symptom management and facilitate goals-of-care discussions between providers, patients and families.

4. **Realign financial incentives to reflect evidence-based guidelines.** Payment rates for technology-oriented procedures are often inflated out of proportion to the degree of their documented effectiveness. As a result, a growing number of procedures which demonstrate little or no benefit over more conservative therapies are being performed. Correcting this will require a significant realignment of current financial incentives. New incentives will need to reflect scientifically based guidelines.

5. **Gifts to health care professionals** by pharmaceutical and device manufacturers historically have been common practice. Decision making about effectiveness when selecting medications and

devices can be compromised. If two products are of relatively equal effectiveness, selection of the higher cost option may be encouraged through gifts from industry.

6. **Disclosure of out of pocket costs** for different treatment options is not part of standard informed consent practices. As a result, traditional market forces that might contribute to cost control are compromised. Patients often have insufficient information to consider small differences in effectiveness along side large differences in cost when making decisions.

Solutions to such monumental problems will, of necessity, be exceedingly **complex**, for the answers will almost certainly involve an integration of:

- the basic health care needs of our pluralistic society;
- the rigorous application of the science of medicine;
- the power of entrenched profitable enterprise;
- the practicalities of finance and
- our heritage of ethical values.

VII. RIGOROUS COST CONTAINMENT

Financing health care. Americans are evenly divided when it comes to financing health care. Half would prefer market solutions---revenue should be generated by value, costs controlled by competition. The other half prefer government solutions—revenue from taxes, costs controlled by budget constraints. The problem is that neither competition nor budgets have been shown to moderate costs. We are reluctant to limit choices even when evidence suggests no differences and choice is driven by perception and expectation rather than actual need.

Controlling medication costs. Oregon has led the way in explicitly demonstrating that many highly advertised drugs have no more therapeutic value than much less expensive ones. It is likely that many other similar circumstances exist for other health products and services. We can not rationalize the purchase of overvalued products/services for some citizens when other citizens do not receive equally effective but less costly products/services.

Value of an evidence-based system. Key to competition and effective budget management is access to credible evidence. Future clinical studies are likely to produce evidence that will inform budget processes and create competition. Oregon's prioritized list can be an effective tool to make use of such evidence. Patients and purchasers can demand value, insist on competition and accept budget constraints when they have access to credible evidence.

Value of electronic support. Multiple technologies (electronic medical records, personal health records, patient registries) will soon provide us with health information that can inform us, both as individuals and communities. The challenge will be to prioritize information strategies that focus on patients, consumers and purchasers, enabling them to determine value, promote competition and eliminate products/services that are unsafe or without added value.

Private markets and public budgets perform ethically when they *balance* the needs of individual patients, industries and communities.

VII. EVALUATING THE ETHICAL BASIS FOR SPECIFIC STRATEGIES

DEGREE OF ETHICAL DIFFICULTY *

A. LEAST DIFFICULT	B. MOST DIFFICULT
Universal Access	Cost Containment
Prioritized List (adopt OHP)	Individual Mandate
Medical Home Care	Single Insurance Exchange
Palliative Care	Eligibility based on income?
Electronic POLST Registry	Strengthen Public Health
Evidenced Based Decision Board	Taxes to fund Health Care Reform?
Reduce Conflict of Interest	Should immigrants be included?

* Reflecting the extent of ethical agreement, society support and potential for financial sustainability are categorized.

A. THE ETHICALLY LEAST DIFFICULT STRATEGIES:

Each of these proposals received clear ethical agreement at this Kinsman Conference. They also have strong societal support and potential for financial sustainability. (Each is discussed in further detail in other sections of this paper).

1. **Universal Access** to a basic package of health care benefits for all *citizens.* (Regarding benefits for immigrants, see discussion in "Most Difficult" section below.)
2. **Prioritized List** (adopt OHP) to define the basic package of benefits based on evidence of effectiveness in either improving *quality* of life and reducing suffering (wheelchairs for the disabled, emergency dental treatment, palliative care) or substantially lengthening the *quantity* of life (e.g. insulin for a diabetic).
3. **Medical Home** is a regular home of medical care that delivers the coordinated, evidence based, patient centered services needed to achieve optional individual and population health.
4. **Electronic POLST Registry** Fund the operation of a statewide electronic POLST Registry to assure that information about patient wishes to have or to limit life sustaining treatment is more uniformly available to emergency medical personnel in a time of crisis.
5. **Palliative Care** Assure that patients with advanced chronic illnesses and their family members have access to the information they need and assistance in deciding on their goals of care, including assistance in completing a POLST form, obtaining effective symptom management and facilitating care coordination.
6. **Evidence-based Decision Board** This oversight board determines and revises the prioritized list. Members of this board must be carefully selected to minimize conflict of interest and maximize the ability of the board to analyze and use evidence of effectiveness.
7. **Reduce Conflict of Interest** Further detail is provided in the "Improve the System" section of this manuscript.

B. <u>THE ETHICALLY MOST DIFFICULT STRATEGIES</u>:

Each of the following strategies contains a substantial ethical conflict, reflecting the tension between two or more credible values (usually market justice and social justice). In these difficult situations, ethics can help achieve resolution in two ways: a) by clarifying underlying values, which often show more agreement than disagreement; b) by facilitating fair *process* (See Section III).

The most contentious of these strategies are:

1. **<u>An individual mandate requiring Oregonians to be insured</u>** for a basic package of effective health services would substantially improve access and decrease the hidden cost shifting which occurs now. Although such a mandate would reduce individual autonomy by a small amount, it would also enlarge the common pool of resources sufficient to make a basic plan of benefits sustainable for all.

2. **<u>A single insurance exchange</u>** that explicitly *balances* the needs of individuals, the priorities of the common pool and the elements of a functional market, is both ethically compelling and historically consistent with previous Oregon policy. To be fair, members of this exchange must follow strict conflict of interest policies (e.g. not represent the specific insurance companies involved). The exchange's processes and decisions will need to be explicit, transparent and reasonable for all.

3. **<u>Eligibility based mainly on income</u>** (not assets) is both ethically sound and administratively practical. Taxing assets, on the other hand, is neither. Protection of assets will likely provide an incentive both timely enrollment and shared responsibility.

4. **<u>Strengthen public health and prevention:</u>** (See Section V) Current technology-dominated medical care is rewarded far out of proportion to its ability to improve population health outcomes. An explicit transfer of resources from medical care to public health will be necessary to accomplish this goal.

5. **<u>Contributions (taxes) will likely be needed to fund transitional elements of Oregon's health care reform,</u>** especially those related to subsidies for low income residents, improvement in primary care infrastructure and public health/population approaches. It is reasonable and progressive for a substantial portion of these contributions to come from the medical care industry (especially those members who have benefited greatly from the current allocation) and from other industries whose employees would benefit from such taxes. A more efficient state system should actively seek to maximize federal matching funds for Oregonians by strongly supporting Oregon's portion of that match. The ethical values of justice and compassion support these suggestions.

6. **<u>Should immigrants be included in the benefits of health care reform?</u>** Disparities in health care are present in Oregon, leading to significant differences in health outcomes. Access to health care is especially difficult for new immigrants. Immigrants make substantial contributions to Oregon's market economy through their labor and purchasing of goods and services. Many immigrants and their children eventually become citizens. Provision of preventive and primary care services would improve the health of the immigrant population, thus reducing both the current and future burden of disease.

IX. ACKNOWLEDGEMENTS

The Kinsman Conference

Each year since 1990, health care ethics leaders from across Oregon have come together for the Kinsman Medical Ethics Conference. The geographic location rotates annually among five Oregon cities. Although the topics change from year to year, the goal of each conference remains the same**:** to bring the rich heritage of medical ethics and the wisdom of ethics leaders to bear on the most pressing medical/ethical challenges facing Oregonians. Past deliberations have exerted a significant effect upon Oregon's health care, particularly in the areas of end-of-life care, health care access, conflict of interest, disclosure of medical errors, respect for refusal of treatment and palliative care, where Oregon has become a national leader.

While accepting the reality that solutions to ethical issues in health care frequently involve political applications, the Kinsman Conference (and this summary paper) always strives to be non-partisan**,** based upon the recognition that ethics evolves from, transcends, and speaks to all political, philosophical, religious and cultural traditions.

The Kinsman Conference is underwritten by an endowment from John Kinsman and is otherwise supported only by the modest registration fees paid by its participants and the generous provision of staff and facilities by its host medical communities each year. This year's conference was co-sponsored by the OHSU Center for Ethics in Health Care and the Department of Continuing Medical Education of Southern Oregon. Support for this conference follows the strict financial conflict of interest policies of the OHSU Center for Ethics in Health Care, which explicitly prohibits the acceptance of pharmaceutical and health care industry support.

Summary Paper

This paper is a summary of the main themes generated by the Kinsman Conference Faculty and 101 participants (mostly ethics leaders from throughout Oregon). The pluralism of these voices represents a broad diversity of viewpoints and does not necessarily imply individual endorsement of the contents of this summary paper. The faculty disclosed no financial conflicts of interest.

The 2008 Kinsman Conference Faculty

James E. Sabin, MD, the 2008 Kinsman keynote speaker, is Director of the Ethics Program at Harvard Pilgrim Health Care and is Clinical Professor of Psychiatry at Harvard Medical School. His major research interests and numerous publications center upon three areas: 1) fair resource allocation in U.S. health care; 2) ethics of managed care; and 3) the role of consumers in health care reform and practice. Through his several talks and generous participation in this Kinsman Conference, he obviously had significant impact upon this conference. He was not directly involved in the writing or editing of this summary. We gratefully acknowledge his many wise and insightful contributions to the 2008 Kinsman Conference and to the people of Oregon.

John W. Forsyth, MD, program chair for the 2008 Kinsman Conference and editor of this summary report, is a retired cardiologist from Medford, Oregon who continues as a volunteer consultant at Community Health Center, a safety-net clinic. In 1994, he was a founder of VOLPACT, a physician volunteer group which currently includes 90% of the private practice physicians in Jackson County. In 1998, he received the OMA's "Physician-Citizen-of-the-Year" award, the Mother Joseph award of the Sisters of Providence Health System and Asante Health System's Alfred Carpenter award, all for service to his local community. He has been a long-standing member of the ethics committees of both Rogue Valley and Providence Medford Medical Center.

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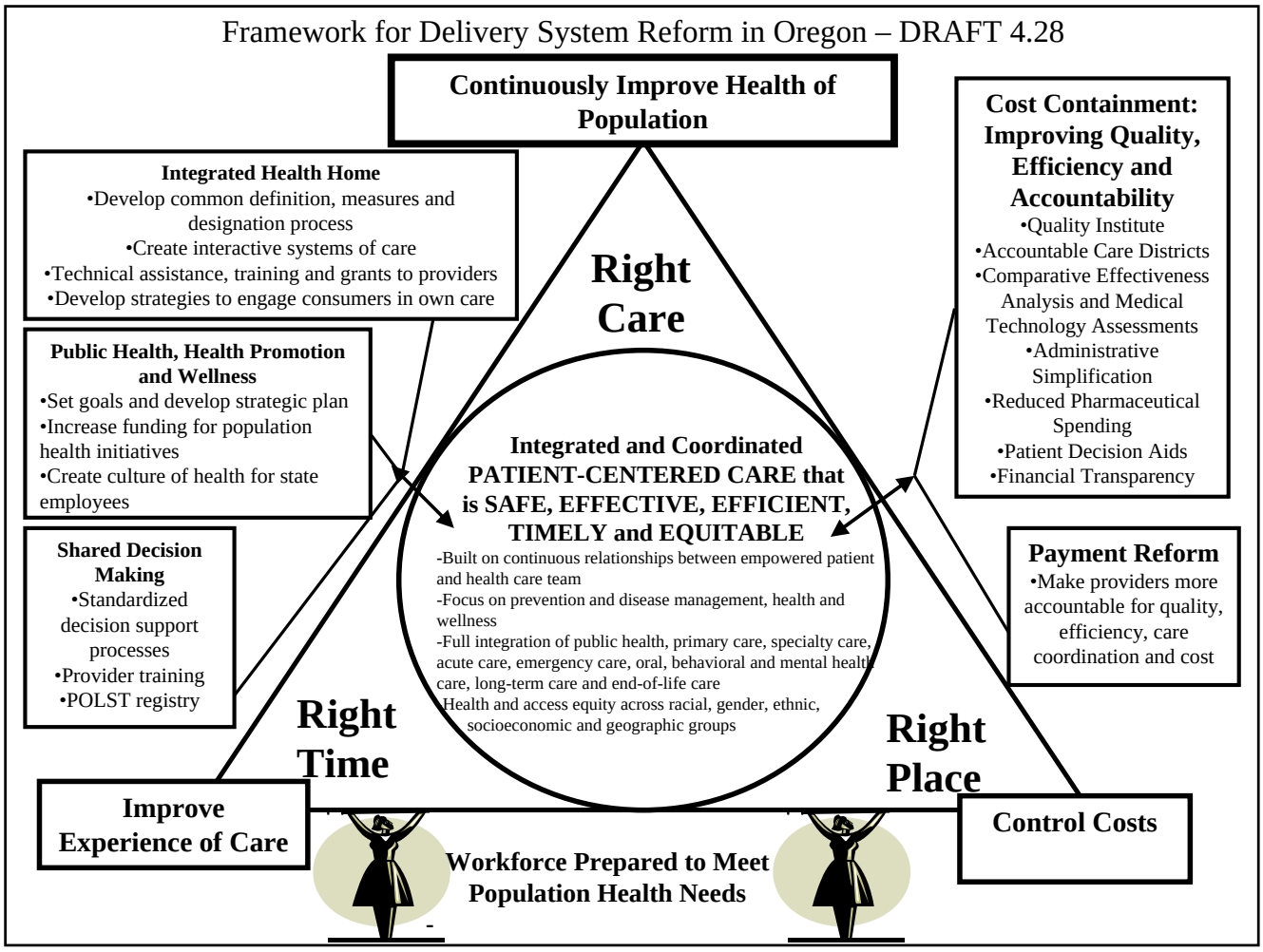
Framework for Delivery System Reform in Oregon – DRAFT 4.28



DOCUMENT A

Oregon Health Fund Board
Delivery Systems Committee
DRAFT Recommendations: Public Health, Health Promotion and Wellness, Payment Reform, Cost Containment (Comparative Effectiveness Analysis and Medical Technology Assessments and Financial Transparency)
FOR DISCUSSION ONLY April 28, 2008

PUBLIC HEALTH, HEALTH PROMOTION AND WELLNESS

Recommendation 1: The state should partner with public and private stakeholders, employers, schools and community organizations to establish priorities and develop aggressive goals for the prevention and reduction of health conditions and behaviors most detrimental to the health of Oregonians, particularly for obesity and tobacco use. The development of the priorities and goals should be aligned with efforts of the Quality Institute to improve the quality of care delivered to Oregonians.

Recommendation 2: The state should partner with local boards of health, providers, employers, schools, community organizations and other stakeholders to develop a statewide strategic plan for achieving these goals. As part of its strategic plan, the state should work with appropriate stakeholders to identify population-based health activities with evidence of improving health outcomes. This should be in collaboration with the efforts of the Quality Institute. The plan should seek to use existing resources more effectively before proposing actions that increase costs or require additional funding. Where it is clear that additional resources are essential in order to carry out the plan, such activities would be considered for funding as presented under Recommendation 3 below.

Recommendation 3: The state should establish and fund a Community-Centered Health Initiatives Fund (CCHI) to fund primary and secondary prevention activities. This fund should be used to provide funding to develop and implement culturally and socially appropriate primary and secondary prevention activities in line with the goals and strategic plan discussed in Recommendations 1 and 2. These activities need to be aligned with the efforts of the Quality Institute to improve quality of care.

Activities funded by CCHI funds will meet the following criteria:

- Be based on community input;
- Be based on evidence and data;
- Will address behavior change a the individual, community and system levels;

- Coordinate efforts of local county health departments, community-based organizations, schools, employers and health care delivery system entities;
- Work to reduce health care disparities;
- Will be accountable for demonstrating measureable improvements in health status, health education and reduction of risk factors.

The funds would be directed to the following components:

Local Initiatives

- A portion of the CCHI will be used to fund activities delivered at the local level by county health departments, community-based organizations and health care delivery system entities. Collaborative coordinating councils (including local boards of health, community coalitions designed to increase access for vulnerable populations and/or improve quality of care, providers, employers, schools, community organizations and others) should be established to develop and implement population health projects, building on existing efforts in the community.
    - Health care delivery system entities receiving Medicaid funding need to be a key aspect of these community efforts both locally and regionally, and must participate in the collaborative coordination councils.
    - Pilot payment reform and other efforts directed to particular accountable care health districts will need to be aligned with these local initiatives.

Regional Initiatives

- A portion of the CCHI will be used to fund regional efforts, particularly where local resources are insufficient to assure standards will be met.

State Initiatives

- A portion of the CCHI will be used to fund the Public Health Division of the Department of Human Services and other state government efforts to play a role in facilitating and coordinating local and regional prevention efforts. These funds will be used for standard setting, coordination, implementation assistance and evaluation in coordination. These activities will be coordinated with the Quality Institute's efforts. In addition, funds will be used to provide administrative support for local, regional and accountable care district initiatives, including:
    - Setting standards of performance for the state-set priority activities, and when appropriate, for other evidence-based prevention projects selected by communities.
    - Ensuring coordination of programs across jurisdiction, including the avoidance of duplicative services.

    - Providing technical assistance to counties, local communities, and delivery system entities to implement prevention projects.
    - Implementing a Prevention Projects Data System including the: development of standardized data elements; creation of data reporting mechanisms; compilation and analysis of data; and issuing an annual report detailing prevention activity performance.
- CCHI funds directed to state government will also be used to conduct state-level, evidence-based prevention and to develop and implement additional evidence-based prevention projects, aligned with the local and regional efforts, the Quality Institute, and other public or private efforts.

Recommendation 4: All state agencies, in partnership with PEBB, should develop a strategic plan for creating a culture of health for state employees. Workplace conditions across state agencies should encourage healthy behaviors, such as healthy eating and physical activity.

PAYMENT REFORM

Recommendation 1: The payment system should be reformed to require health care providers to be accountable for quality, efficiency and care coordination. A payment reform council should be established within the Oregon Health Fund Board, Quality Institute or a state agency, to develop specific recommendations for comprehensive payment reform guided by the principles and goals below. By January 2011(??), the council will establish initial rules for a payment system that is aligned with the goals of the Quality Institute and other entities created through reform and links levels of payment to quality, efficiency and care coordination. This new payment system will apply broadly to the entire delivery system, with specific features to promote and support the integrated health home model. The council will publicize and promote the new payment system, monitor the progress of public and private payment entities in adopting the payment system, provide technical assistance to entities adopting the payment system and continuously update the system. In addition, the council should partner with the Quality Institute to evaluate the effects of payment reform on health care delivery and spending.

Goals of a new payment system:

1. Improve population health and patient experience with care
    - Reward providers for good health outcomes.
    - Improve coordination and management of care, especially for people with chronic disease and reward providers who care for patients with complex care needs and/or multiple chronic conditions.
    - Strengthen primary care and support delivery system redesign centered around the integrated health home model.
    - Encourage providers to care for all patients, regardless of health status.
    - Encourage patient choices that improve adherence to recommended care processes, improve outcomes and reduce the costs of care.

2. Make providers more accountable for delivering high-quality, efficient care
    - Enable and encourage providers to deliver high-quality, efficient, patient-centered care that is based on best available evidence and aligned with guidelines endorsed by the Quality Institute.
    - Make providers responsible for quality and costs within their control.
    - Remove incentives for overtreatment, use of unnecessarily expensive services, unnecessary hospitalizations or re-hospitalizations, errors or adverse events, provision of services with poor patient outcomes, inefficient service delivery and encouraging choices about preference-sensitive services that are not compatible with patient desires.

3. Control Costs
    - Reduce overall health care spending.
    - Increase competition based on quality, efficiency, patient-centeredness and value of care provided.
    - Reward providers who innovate in finding ways to deliver health care that result in higher quality and lower cost care.
    - Move toward a system that requires providers to be more accountable for the total cost of care.
    - Align standards and methods of payments across the delivery system to minimize the administrative costs for providers in complying with multiple payment system requirements.

Design principles:

- Develop a mechanism to increase the public transparency of prices for health care services.
- Reduce administrative burden.
- Include providers in the design process in order to develop an effective design.
- Place higher relative value on primary care, case management and other cognitive services relative to specialty care.
- Fairly reimburse providers for delivering services, for which they are currently not compensated, that increase quality and improve patient experience, including but not limited to:
    - Telephone and email communication;
    - Pharmacist medication management;
    - Behavioral health counseling;
    - Palliative care services; and
    - Conversations with patients about their goals of care and advance directive and POLST (for patients with advanced chronic disease) preferences.
- Develop a staged plan to allow for differences in provider and plan capacity to move to new payment models. The system should be continuously updated with the goals of developing a system that rewards providers who meet specific quality and efficiency targets, take responsibility for managing and coordinating patient care and follow evidence-based guidelines.
- Adjust payment for risk based on incidence of illness in a given population.
- Ensure a majority of providers and payers participate in payment reform so the system is efficient and cost-effective.

- Evaluate the effect of new payment strategies on total health care spending and the goals of improved quality, efficiency and care coordination.

Recommendation 2: New payment models should be piloted within the infrastructure established by delivery system reform. Accountable care districts will provide opportunities to experiment with establishing global budgets for communities and evaluating the effectiveness of this strategy.

COST CONTAINMENT – COMPARATIVE EFFECTIVENESS AND MEDICAL TECHNOLOGY ASSESSMENT

Recommendation 1: Streamline and strengthen efforts to support comparative effectiveness research and ensure policy decisions are informed by the best available evidence. The state, lead by the Health Resources Commission (HRC), should partner with other state and national public and private stakeholder groups already investing in comparative effectiveness research to create a more collaborative and coordinated effort. Funding for the HRC should be increased to allow the group to partner with existing state and national efforts, support high quality research and use the best available data and evidence to make public and transparent policy decisions. Comparative effectiveness research must be made available to Accountable Care District Authorities to inform decisions about health resource planning.

Recommendation 2: Develop standard sets of evidence-based guidelines for Oregon. The state, led by the Quality Institute, Health Services Commission and Health Resources Commission, should lead a collaborative group of public and private purchasers and health plans in endorsing standard sets of clinical and social support guidelines for all providers serving Oregonians. This collaborative group should build on existing local, state and national efforts and review and endorse existing high-quality guidelines whenever possible. Where guidelines do not exist, the group should convene expert groups to create them. Standard guidelines should be updated as new research and data becomes available and evaluated over time to measure the effect on individual and population health and effective use of health care resources. Providers should be required to use these guidelines in caring for patients in state funded health programs (OHP, OHFP, PEBB, OEBB). Private purchasers and health plans should develop policies that encourage the utilization of these guidelines. Initial efforts should be focused on identifying standard guidelines for the most prevalent chronic diseases.

Recommendation 3: Develop common policies across pubic and private health plans regarding the coverage of new and existing treatments, procedures and services. The state, lead by the Quality Institute, Health Resources Commission and Health Services Commission, should lead a collaborative group of public and private purchasers and health plans in developing consistent policies regarding the coverage of new and existing treatments, procedures and services. Whenever possible, coverage decisions should be made based on comparative effectiveness research and evidence and should be made based on the relative value of a treatment, procedure or service to the population as a whole. Where clear evidence does not exist, coverage decisions should be based on widely accepted best practices and standards of care.

COST CONTAINMENT – FINANCIAL TRANSPARENCY

Recommendation 1: Develop new regulations which require hospitals and ambulatory surgery and imaging centers to be more transparent and public about their financial data, including profit, operating margin and reserves.

DOCUMENT B
Oregon Health Fund Board
Delivery Systems Committee
DRAFT Recommendations: Integrated Health Home, Shared Decision Making, Cost Containment (Quality Institute, Accountable Care Districts, Administrative Simplification, Reduced Pharmaceutical Spending, Patient Decision Aids)
FOR DISCUSSION ONLY April 28, 2008

INTEGRATED HEALTH HOME

Oregon's primary health care delivery system must be radically transformed in an effort to improve individual and population health and wellness. This transformation should be guided by the concept of the integrated health home and must involve a revitalization of primary care, as well as other health and social services that are to vital components of a system equipped to meet the health needs of the population. The state should take bold steps to partner with consumers, providers, purchasers and payers around the common goal and vision of providing every Oregonian with an integrated health home.

Recommendation 1: Promote and support patient-centered integrated health homes to be available for all participants in the Oregon Health Fund Board Program, with eventual statewide adoption to ensure integrated health homes are available to all Oregonians. Initial focus should be placed on providing medical homes for people with chronic conditions.

Timeline: Within 3 years, every member of the Oregon Health Fund Program should have access to an integrated health home. Within 5 years there should be widespread statewide adoption of the integrated health home model that ensures every Oregonian has access to an integrated health home.

Definition: A standard definition of integrated health home should be developed for Oregon that allows for innovation and encompasses a range of models. The Delivery System Committee recommends the following definition, which is a modified definition of a patient-centered medical home, as developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA).
Key aspects to include are:

- *Personal connection with practice* **–** Every patient has available an established and continuous relationship with a provider or provider group working in a practice that meets all criteria of an integrated health home. This could be with a primary care physician, nurse practitioner or others trained to provide

longitudinal health care services. These services can be provided within the care setting or through coordinated virtual networks.

- *Team-based Care* - A coherent team of providers working at the top of their licenses, who are collectively responsible for the patient's longitudinal health needs. Empowered patient and patient's family (when appropriate) play active and central role in team-based care. Roles within the team are assigned to maximize the efficient use of resources and responsiveness to patient needs.
- *Whole Person Orientation* **–** Integrated health homes assumes responsibility for providing culturally competent care for all of the patient's health care needs, including wellness, preventive care, disease management services, acute care and end of life. The integrated health home provides direct care when possible and arranges for appropriate referrals to other providers and other health and social services.
- *Coordinated and Integrated Care* **-** Care received from the integrated health home is coordinated/integrated with care received from other providers and organizations, as well as with services provided within a patient's community, including public health, oral health, mental health, and behavioral health services, including Employee Assistance Programs. Coordination allows patients to receive appropriate care when and where they need it. Registries, information technology, information exchange, and other resources are utilized by the integrated health home to establish and facilitate coordination.
- *Quality and Safety* **–** Integrated health homes focus on quality improvement and safety, through physician participation in performance measurement and improvement efforts, use of clinical decision-support technology, and clinical standards and guidelines built on evidence-based medicine. Patients participate in shared decision-making, quality improvement efforts and practice evaluation.
- *Enhanced Access* – Patient access to both office-based and non-office based care is expanded through mechanisms such as longer hours, group visits, open scheduling, phone and email visits, and other web-based communication.

Recommendation 2: Create and support interactive systems of care (real and virtual) which connect integrated health homes with community-based services, public health, behavioral health (including Employee Assistance Programs), oral health, and social services to improve population health.
These systems should have the ability to provide feedback on population health statistics, population based outcomes measures and improvement across the delivery system. Systems should be established to coordinate and support each service provider, use resources efficiently and minimize duplication of efforts.

Recommendation 3: Provide Oregon's health care workforce with technical assistance, resources, training and support needed to transform practices into integrated health homes. This support must be provided to Oregon's primary care workforce, as well as other health care and social service personnel needed to provide individual and population health, coordination and management services vital to the integrated health home model. In addition, educational programs must be established to help institutions training health care professionals to change their curricula to include the integrated health home model.

Options to consider:

- Forum for those participating/funding demonstration projects to come together to share best practices and discuss challenges.
- Learning opportunities that give providers and other stakeholders the chance to partner with public health to facilitate the use of data to improve individual and population health.
- Funds for demonstration projects, especially in rural and underserved areas. May consider funding demonstration projects where specialist (e.g. endocrinologist for patient with diabetes, mental health professional for patient with mental illness, dentist) serves as integrated health home.
- Grants to practices to build HIT infrastructure, disease registries, etc.
- Ongoing funding for practices dedicated to making the transformation into integrated health homes to support the development and completion of transition plans.
- System improvement training and other technical assistance.

Recommendation 4: Develop and evaluate strategies to empower consumers to become more involved in their own health and health care by partnering and engaging with integrated health homes.

Options to consider:

- Pilot and evaluate strategies to provide rewards/incentives for Oregon Health Fund Program participants who enroll with integrated health homes, seek preventative and wellness services, practice healthy behaviors, effectively manage chronic disease with support from health homes, etc.
- Develop tools and provide training to help providers more effectively communicate with patients and to provide culturally appropriate care
- Educate public about benefits of enrolling with integrated health homes
- Explore opportunities to integrate shared decision making tools into care of Oregon Health Fund Program enrollees, as well as other Oregonians (See Decision Support Recommendations).

Recommendation 5: Develop funding, payment and incentivizing strategies that promote and sustain integrated health homes and other system of care partners.

1) Acknowledge and support initial pilots underway across the state and use the lessons and best practices from these pilots to design, promote and/or fund a larger scale continuous rollout of the integrated health home model. This rollout should aim to develop new integrated health home models, as well as new models of reimbursement that adequately compensate and support providers and other associated workforce personnel for delivering integrated health home services.

2) Develop standard policies that tie reimbursement to requirements to report on common measures of integrated health home process and performance and system performance measures.
- The common set of measures should be developed via the Quality Institute, which should be responsible for coordinating the collection of baseline data and ongoing performance data. Measurements should build on national standards and current efforts to measure quality, cost, and efficiency in Oregon. Measures should include process and outcomes measures, be designed to measure longitudinal clinical outcomes for individuals as well as provider panels, and include measures of population health. A process should be developed to ensure that measurement processes are fluid and regularly updated.
- Common measures should allow for comparative analysis of integrated health homes to improve individual and population health, as well as patient and physician experience.

3) Design a simple and standard process to designate primary care practices as integrated health home. The designation process should be based on measurements included in the common set of measures (see #2 above).
- Designation process must be simple and tiered to acknowledge various levels of progress toward evolution into fully integrated health homes.
- Designation process should be built on common measures to minimize burden of reporting requirements on providers.
- Payment for integrated health homes (see #4 below) should be based on tiered designation process.

4) Develop long-term sustainable payment policies that appropriately compensate providers and other partners involved in integrated health home systems of care. Compensation should be provided for developing capacity to provide integrated health home services and for providing these services to Oregonians in a high-quality and high-value manner. New payment strategies should be tested and evaluated to determine the potential to

improve patient outcomes and experience, as well as provider experience. These new payment strategies should be part of a comprehensive payment reform strategy.

- A mixed model of reimbursement will have to be developed, which includes fee for service payments for certain procedures and risk-adjusted bundled payments for providing integrated health home services
- Payment should be tied to reporting requirements of common measures (see #2 above) and an auditing process will have to be developed.

SHARED DECISION MAKING

Recommendation 1: The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should develop or endorse evidence-based standardized decision support processes for integrated health homes and other care settings, which account for patients' cultural, ethnic, racial and language needs. Decision support processes should identify opportunities for members of the care team and patients to discuss alternate treatments and patient preferences and should include the use of patient decision aids where appropriate. Initial efforts should be focused on developing shared decision making processes for patients with advanced chronic illness, who are hospitalized or have been recently hospitalized. These processes should aid patients in making decisions about goals of care and give them the opportunity to complete advanced directives and Physician Orders for Life-Sustaining Treatment (POLST), where appropriate.

Recommendation 2: New payment methods should be used to encourage providers in state funded and private health programs to use decision making support processes and reimburse them for time spent engaged in tasks associated with these processes.

Recommendation 3: The state should seek opportunities to partner with public and private stakeholders to develop and offer training courses to providers in facilitating shared decision making processes. Specific attention should be focused on training providers who work with patients with chronic illness.

Recommendation 4: A statewide electronic POLST Registry should be created to ensure the availability of the POLST form at the time of need.

COST CONTAINMENT - QUALITY INSTITUTE

Place Holder - Recommendations included in the Quality Institute Work Group Report with the qualifying letter from the Delivery Systems Committee to reflect April 17 conversation.

COST CONTAINMENT - ACCOUNTABLE CARE DISTRICTS

Recommendation 1: Establish Accountable Care Districts and aggregate quality and utilization data by Accountable Care Districts. Health care quality data reported by the Oregon Quality Institute will aggregated to allow for meaningful comparisons of quality and utilization data across the state and across ACDs.

ACDs will have to be established across the health care delivery system, but do not necessarily require new financial relationships between providers and hospitals and could be identified in a number of ways. Options for identifying ACDs:

- Defined empirically through claims data
- Large multi-specialty group practices with own hospitals
- Physician-Hospital Organizations
- Hospitals that own physician groups
- Extended Hospital Medical Staff (virtual or multi-specialty group practice directly or indirectly affiliated with a single hospital)
- Geographic area (e.g. county or education service district)

Recommendation 2: Create a pilot project that establishes Accountable Care District Authorities to use evidence and data to make health planning and resource utilization decisions and serve as a framework for payment reform. Accountable care district pilot projects should be funded by the state to establish collaborative, community-based ACD authorities in a minimum of three communities across Oregon. These ACD authorities should use aggregated data to make collaborative health planning and resource utilization decisions and serve as a framework to pilot new reimbursement models, such as care coordination fees and global budgets. Grant applicants should be evaluated based on the feasibility of community collaboration across stakeholder groups and the use of data to drive change. Other communities should be encouraged to voluntarily participate in the pilot, but may not be provided with grant funding. The organization and staffing of ACD authorities should be determined by the pilot communities and ACD stakeholder groups.

By **2012 (??)** all ACDs in Oregon should establish an ACD authority to use aggregated data to make collaborative health planning and resource utilization

decisions and provide a framework for new reimbursement models. Evidence from data aggregation, as well as lessons and best practices from the pilot projects, should guide this process, but communities and ACD stakeholder groups should play a significant role in determining the structure and staffing model for each ACD.

COST CONTAINMENT – ADMINISTRATIVE SIMPLIFICATION AND STANDARDIZATION

Recommendation 1: Increase transparency surrounding health plan administrative spending. The state should convene public and private health plans, hospitals and providers to:

- Develop a standard definition of "administrative costs" for health plans
- Develop requirements for all health plans (including Oregon Health Program) to be transparent about the % of premiums that are used for administrative costs and process for making this information easily available to the public

Recommendation 2: Develop standard formats and processes for eligibility, claims and payment and remittance transactions. The state should partner with private stakeholders to build on efforts to develop standards, formats and rules for eligibility, claims, and payment and remittance transactions. By 2010(?), all providers and purchasers should be required to use standard formats and electronic exchange for these transactions (modeled after Minnesota Administrative Simplification Act).

COST CONTAINMENT – REDUCED PHARMACEUTICAL SPENDING

Recommendation 1: Expand enrollment in the Oregon Prescription Drug Program. All state funded health programs should purchase pharmaceuticals for enrollees through the Oregon Prescription Drug Program (OPDP) and the Northwest Prescription Drug Consortium. All health plans should be required to use OPDP unless they can show greater cost savings for their enrollees through other purchasing contracts.

Recommendation 2: Develop a single pharmaceutical formulary for Oregon. The state should collaborate with private stakeholders to develop a single pharmaceutical formulary for Oregon, as well as a collaborative process to regularly review and update the formulary. All state funded health plans (OHP, OHFP, PEBB, OEBB) should be required to use this formulary. Private health plans should be encouraged to utilize the formulary.

COST CONTAINMENT – PATIENT DECISION AIDS

Recommendation 1: Endorse patient decision aids shown to increase the use of cost-effective care. The Oregon Health Fund Program (via the Quality Institute, HRC, HSC or other health commission) should identify and endorse the use of patient decision aids that have been shown to improve the quality of clinical decision making and increase the use of cost-effective medical interventions for preference-sensitive care. Decision aids should be evaluated for their ability to meet patients' cultural, ethnic, racial and language needs. There should be a focus on identifying effective patient decision aids for conditions involving expensive, invasive and discretionary surgical procedures.

Recommendation 2: Require patients to use evidence-based patient decision aids prior to having high-cost, preference-sensitive procedures. State funded health program enrollees should be required to utilize patient decision aids endorsed via Recommendation 1 before having related high-cost, preference-sensitive procedures. Private purchasers and health plans should be encouraged to adopt similar policies.

Recommendation 3: Pass legislation in support of the use of patient decision aids. Legislation should be passed (modeled after Washington State ESSB 5930) which provides a higher standard of immunity for providers who use patient decision aids from litigation based on failure to provide informed consent.

Oregon

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To: Members of the Oregon Health Fund Board
From: Members of the Oregon Health Fund Board Delivery Systems Committee
Subject: Quality Institute Work Group Report to the Delivery Committee
Date: April 23, 2008

On April 17, 2008 the Delivery Systems Committee received the enclosed report from its Quality Institute Work Group. The Committee agrees that ongoing quality assessment and a process for quality improvement is the keystone of any viable health care system and must be a central focus of any health reform plan. A single entity is needed to set the quality agenda for Oregon and lead and unify existing quality initiatives in a collaborative effort to move the state toward a higher performing health system. Therefore, the Delivery Systems Committee endorses the recommendations, but suggests that the Board consider the following issues before making final recommendations. The points below reflect suggestions made by Committee members during the April 17 meeting.

- **Clarify and strengthen language about aligning stakeholders around common quality metrics and setting standards for data collection and reporting**. The Quality Institute should set standards for what metrics are collected and reported and how data is collected and reported. Standards should aim to simplify and streamline processes, allow for meaningful comparisons across the health care system and reduce administrative costs associated with reporting different sets of measures to different purchasers and health plans. In addition, the Quality Institute should set performance benchmarks that can be adapted over time.

- **Efforts of the Quality Institute must support and be aligned with Accountable Care Districts and reform evaluation.** The data collected and reported by the Quality Institute should support performance evaluation within the healthcare system, but must also support community evaluation of performance. The Quality Institute should report data in a way that allows for meaningful comparisons across communities and accountable care districts. In addition, the Quality Institute must collect and report data that aligns and supports efforts to evaluate state funded health programs and health care reform.

- **Providing understandable and meaningful information about quality to consumers must be a priority.** "Understandable" should be added to the definition of transparency to reflect the need to ensure that public reporting be done in a way that is meaningful to lay persons. Recommendations should be reordered to put more of an emphasis on

the need to engage and support consumers in quality improvement initiatives.

- **The recommended structure should be revisited after a comprehensive plan is developed.** Members questioned whether there would be a need for a separate and distinct Quality Institute with all of the entities created through reform. Members also suggested that the Board assess the role of private stakeholders in the public-private structure and suggested that these stakeholders provide specific testimony as to how a Quality Institute could enhance current efforts.
- **Greater transparency around cost is vital to reform and cost containment efforts.** The Delivery Committee did not necessarily recommend that the Quality Institute should take a more significant role in reporting data associated with costs than was recommended by the Work Group, but suggested that cost transparency needs to be addressed throughout the reform process.

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About PART B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using PART B of this form. Your representative must accept on PART E of this form.

In this document, you can write any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About PART C (Giving Health Care Instruction)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using PART C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE, and ADDRESS here:

_____
(Name)

_____
(Birthdate)

_____

_____
(Address)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

_____ My entire life

_____ Other period (_____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ as my health care representative.

My representative's address is _____

and telephone number is _____.

I appoint _____ as my alternate health care

representative. My alternate's address is _____

and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption, or that person was appointed before your admission into the health care facility.

PART B: APPOINTMENT OF HEALH CARE REPRESENTATIVE (CONTINUED)

1. Limits.

Special Conditions or Instructions: _____

_____

_____

INITIAL IF THIS APPLIES:

_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

"Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

_____

(Date)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

_____

(Signature of person making appointment)

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in PART B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone that moment of my death:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____ I want any other life support that may apply.
   _____ I want life support only as my physician recommends.
   _____ I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____ I want any other life support that may apply.
   _____ I want life support only as my physician recommends.
   _____ I want NO life support.

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____ I want any other life support that may apply.
   _____ I want life support only as my physician recommends.
   _____ I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

   A. INITIAL ONE:
   _____ I want to receive tube feeding.
   _____ I want tube feeding only as my physician recommends.
   _____ I DO NOT WANT tube feeding.

   B. INITIAL ONE:
   _____I want any other life support that may apply.
   _____I want life support only as my physician recommends.
   _____I want NO life support.

5. General Instruction.

   INITIAL IF THIS APPLIES:
   _____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions. (Insert description of what you want done.)

_____

_____

_____

_____

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

_____ I have a health care power of attorney, and I REVOKE IT.

_____I DO NOT have a health care power of attorney.

_____

(Date)

SIGN HERE TO GIVE INSTRUCTIONS

_____

(Signature)

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;
(b) Signed or acknowledged that person's signature on the advance directive in our presence;
(c) Appears to be of sound mind and not under duress, fraud or undue influence;
(d) Has not appointed either of us as health care representative or alternative representative; and
(e) Is not a patient for whom either of us is attending physician.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

_____

(Signature of Health Care Representative/Date)

_____

(Printed Name)

_____

(Signature of Alternate Health Care Representative/Date)

_____

(Printed Name)

OREGON HEALTH FUND BOARD – Delivery Systems Committee

May 14, 2008
1 – 5 pm

Portland State Office Building, 1st Floor Room 1A
800 NE Oregon Street
Portland, Oregon

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Doug Walta, MD, Vice-Chair
Vanetta Abdellatif
Mitch Anderson
Tina Castanares, MD
Vickie Gates
Bill Humbert
Dale Johnson
Carolyn Kohn
Bart McMullan, MD
Stefan Ostrach (by phone)
Ken Provencher (by phone)
Lillian Shirley, RN
Mike Shirtcliff, DMD
Charlie Tragesser
Rick Wopat, MD

MEMBERS ABSENT:
David Ford
Diane Lovell

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPPR
Ilana Weinbaum, Policy Analyst, OHFB

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

- **Identify Key Area of Draft Report for Discussion**
- **Discuss Key areas of Draft Report**
- **Public Testimony**

[DISCLAIMER: There was a malfunction of the digital recorder used to record this meeting. As a result, only a portion of the beginning of the meeting was recorded. However, every attempt has been made to recreate an accurate summary of what occurred at this meeting.]

Chair Stenson **I. Call to Order/Approval of 04/28/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Chair Stenson **II. Identify Key Areas of Draft Report for Discussion**

Chair asked members to identify areas that need further discussion. Members responded suggesting the following areas:

- Wordsmithing document headed **Public Health, Prevention and Wellness (See Exhibit Materials _____)**
- Accountable Care Districts (ACDs)

- Written comments from Carolyn Kohn, Stefan Ostrach and Mitch Anderson will be considered.
- Cost Containment

Staff related that Chair of the Safety Net Advisory Council will address the Committee regarding their submitted comments.

Chair Stenson **III. Discussion of Key areas of Draft Report (See Exhibit Materials 3)**

Vision Statement (page 7)

- Lead Staff Jeanene Smith related that statement includes attempts to capture comments from presentation by Dave Ford at last meeting and principles discussed over series of meetings. Have not received any email feedback on the statement.
  - Suggestion to add definition of mental health care in Vision Statement and Glossary of Terms. Discussion on definition of health care as including physical, mental, dental, etc.
  - Third hollow bullet (Institute of Medicine's Six Aims): Suggestion to put in the systems and footnote Institute of Medicine reference.
  - Equitable referencing piece not strong enough, needs statement emphasizing it is for all.
  - First hollow bullet: "medicalizing" things that are not medical and not related to the delivery system by nature noted.
  - Committee recommended that Vision Statement is actually just the first paragraph. It should be succinct.
    - Separate first paragraph (minus last line) and bold for Vision Statement.
  - Top of page 8, first full statement, wordsmith adding to ". . . rates higher in efficiency" and add "a position that could easily erode if supply of services increases too quickly." Need to be clear that we are not performing well and need to change.
  - Define what is meant by access suggested.
  - High unit prices for hospital and low utilization. Suggestion that instead of talking about rank
    - Delete first part of statement to begin with "There is still a great deal that Oregon can . . ." and do not use any comparisons. ILANA NO-YES SOUNDS LIKE HE TOOK IT BACK????

Accountable Care Districts (page 32)

- Actual recommendations are in bold on page 33.
- Deals with what data collection and aggregation could do.
- Debate on detail of accountability, with some members asserting document reflects no sense of true accountability and does not prescribe how the data is governed or used. In opposition, importance of collecting data for transparency and in driving policy is asserted. Specificity on governance and accountability vs. providing guidance that others will need to create model.
- Support for community use of data.
- Page 32, last paragraph, statement in parentheses should be expanded to include "shared accountability of quality across the community" that also will include school systems, other agencies, etc., relating it should be honed by communities recognizing that it may be different from region to region.

- Related study to be published in public journal comparing ER use by OHP patients regionally. Indications are that it will be dramatic.
- Do we need a second recommendation or just an extra sentence?

Payment Reform

Others identified by Committee

Chair Stenson **IV. Public Testimony**

Chair Stenson **V. Adjourn**

Motion to adjourn is seconded. **Motion passed unanimously.** Chair Stenson adjourned the meeting.

Next meeting is May 28, 2008.

Submitted By: Paula Hird Reviewed By:

EXIHIBIT SUMMARY

1. Agenda
2. Minutes from 04/28/08.
3. Delivery Recommendations
4. Oregon Primary Care Association
5. Safety Net Advisory Council Recommendations
6. Safety Net Advisory Council Testimony

OREGON HEALTH FUND BOARD – DELIVERY SYSTEMS COMMITTEE

May 28, 2008
1:30 p.m. to 3:30 p.m.
Digitally Recorded

Portland State Office Bldg., First Floor, Room 1B
800 NE Oregon St.
Portland, Oregon

ATTENDANCE NEEDS TO BE CHECKED

MEMBERS PRESENT:
Dick Stenson, Chair
Maribeth Healey, Vice-Chair
Doug Walta, MD, Vice-Chair
Vanetta Abdellatif
Mitch Anderson (by phone)
Tina Castanares, MD
David Ford (did he leave?)
Dale Johnson
Carolyn Kohn
Bart McMullan, MD
Stefan Ostrach
Charlie Tragesser
Rick Wopat, MD

MEMBERS ABSENT:
Vicki Gates
Bull Humbert
Ken Provencher
Diane Lovell
Lillian Shirley, RN
Mike Shirtcliff, DMD

STAFF PRESENT:
Jeanene Smith, MD, Administrator, OHPR
Ilana Weinbaum, Policy Analyst, OHFB
Judy Morrow, Assistant, OHPR

- **Call to Order. Approval of 05/14/08 Meeting Minutes**
- **Brief Update of Delivery Systems Presentation to Board**
- **Public Testimony**
- **Review and Vote on Revised Committee Report**

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Digitally Recorded

Chair Stenson **I. Call to Order/Approval of 05/14/08 Meeting Minutes (See Exhibit Materials 1)**

- Meeting was called to order. There was a quorum.

Motion to approve minutes is seconded. **Motion passed unanimously.**

Chair Stenson **II. Brief Update of Delivery Systems Presentation to Board**

Jeanene Smith reported that she, Dick, Maribeth, and Ilana presented the Committee's recommendations to the Oregon Health Fund Board (OHFB) last week.

- Next steps to be taken by the Board were discussed. Final report will be available soon with changes highlighted. Related the integration of Health Equities Committee (HEC) recommendations into the plan.
- Next Board meeting will focus on Finance Committee
- Stefan Ostrach stated there are fundamental problems with the recommendations and that he will be voting no. Will distribute written issues of concern.
  - Staff noted discussions in the recommendation that relay varying member opinions. Stefan responded that it does not go far enough.
- Tina Castanares stated that the last bullet on page 1 of the Member Comments that was attributed to her is incorrect. **(See Exhibit Materials 3)**
- At the request of the Chair, Stefan summarized his concerns stating:
  - SB 329 is flawed,
  - By taking the single payer off of the table, the real reform needed is not even under consideration and a world class system cannot be built on private insurance.
  - In the short term, Integrated Health Care Homes (IHH) will be more costly, and there is no evidence of long-term savings or that people want them.
  - Agrees with data collection but sees the Quality Institute (QI) as a duplicative bureaucracy and the work should be done by Oregon Health Policy and Research (OHPR).
  - No serious cost containment in recommendations.
  - Incentives for health care quality and outcomes is not needed.
  - Holding increase in costs to CPI is related as "lip service."
- Chair asked if there were objections to Stefan writing a minority report. No objections presented.
  - Support for Stefan's concern on the viability of the health home, but views work as a directive and supports pilots/ experiments.
  - Linking health care costs to CPI supported.
  - Further support that not everyone wants a health home.
  - Maribeth Healey questioned whether the objective of cost containment had been addressed and stated that the Board wants *"more meat"* around it.

Chair Stenson **III. Public Testimony – (Moved to end of report review)**

Chair Stenson **IV. Reivew and Vote on Revised Committee Report (See Exhibit Materials 3 and 4)**

Using Committee Members Comments **(see Exhibit Materials 3)**, Chair related them to the Committee's recommendations **(see Exhibit Materials 4).**

- First comment from Ken Provencher related. No action required.
- **Vision Statement**: Agreement to include Tina Castanares comments.
- **Primary Care / IHH sections**: First Bullet (Recommendation 8, page 28 of plan)
  - Discussion on removing statement that safety net providers may not be needed with debate on safety net clinics as part of the system and their role in a reform system as changing. Statement that under universal care, 5% of population is still uninsured.
  - Debate on if there has been a lobbying effort by safety net people to get protection. Chair proposed to say "may" not be needed from "would" not be needed. Tina Castanares, who submitted

safety net language, denied lobbying efforts, asserted it is in the public's interest to support. Commonwealth report related Oregon ranks 43rd on children's healthcare and 47th in equity in the nation.

Motion to change remove discussion on safety nets is seconded.

Discussion

- Arguments against the motion, stating that it was important that the report to the Board include the Committee's deliberations.

Call for the Question. **Motion fails 5-8.**

On page 28, further discussion should be stricken.

Opposition to the motion and supports leaving in the discussion. Support expressed.

Motion to change recommendation 8 to add "and integrate" to read "Recognize and strengethn and integrate the role of the safety net . . . " is seconded..

Discussion

- Suggestion to include language of "until no longer necessary," with discussion following.
- Statement that this is only the first step for this document and it will be changed by others. Suggestion to leave it as it is.
- Assertion no other states are debating the value of the safety net.

Call for the question. Motion passed unanimously.

- **Primary Care / IHH sections.** Second/Third Bullet overviewed.
  - **Plan recommendation 2 on page 74 (Appendix H)** – Suggestion to move from Appendix to be included in **Recommendation 5 (page 26).**
  - Opposition stated that it is not just safety net providers and should not be changed.
  - Suggestion to recommend ensuring adequate safety net workforce to the OHFB.
  - Discussion of bolded language constituting Recommendation 5 should call out the safety net workforce.
  - What about those that are not defined as safety net?

Motion to change Recommendation 5 from ". . . especially those serving vulnerable populations" to "especially the safety net workforce and those serving vulnerable populations" is seconded.

Discussion

- Objection to calling out specific groups which may adversely affects others serving those populations.
- Prioritizing and importance of safety net providers as a subset is discussed.
- Assertion that the safety net designation is broad and that should be stated.

Call for the question. Motion ???????? – couldn't tell if it passed or not. (56:20)

- **Quality Institute sections**: First Bullet
  - Discussion on electronic health records not being included in recommendations due to this being assigned to the newly formed Health Information Infrastructure Advisory Committee (HIIAC).
  - The need for these systems to be integrated.
  - Issue identified on page 33 of recommendations.

Motion for Committee to "visibly" reflect and explain to HIIAC that this Committee will fully and strongly support the development of electronic health records, that interoperability needs to be high on the agenda and there should be special attention to safety net providers and those that may have more difficulty in attaining that standard. Motion seconded.

Staff related that the recommendations will be related to HIIAC tomorrow as they want to make ensure recommendations intertwine with this Committee's recommendations.
Motion passed unanimously.

- **ACD Sections –** Suggestion to add Safety Net Advisory Council (SNAC) recommendation 3 of Appendix H (page 74) to C. Accountable Care Districts (ACDs) on pages 35-37. Suggestion to add a third recommendation.
- Related that it is included under Further Discussion of Recommendation 1 on page 37.

Motion to add bullet on page 37 to include safety nets and "others serving vulnerable populations" is seconded. **Motion passed unanimously.**

- **Payment Reform Sections:** Tina Castanares related that she did not make the statement at the bottom of page one of the Member Comments document that a dollar amount be attached and supported not including an amount. Discussion on SNAC recommendation .

Motion to include SNAC's recommendation #1 to establish a Safety Net Integrity Fund is seconded.

Discussion

- Concern expressed about asking for money for the safety nets, money for QI, the CCHI fund and how does it interlink with the broader reform?
- Important distinction is noted that access is the Committee's charge, not coverage. It was noted other states have a similar fund.
- Joel Young, Oregon Department of Human Services, staff to SNAC, described the concept of a Safety Net Integrity fund as a new fund to Oregon that would help where gaps may exist and to sustain entities. It is to be used to help establish and meant to be a constant flow of funds.
  - It would help entities with financial trouble with discussion on poor management.
  - Criteria would establish who would be eligible for the fund.

Call for the Question. Motion fails.

- Other Comments: Suggestion does not require action but meant to make OHFB aware stating that they have received an email on it.
- Importance in cost containment asserted.
- Debate on whether insurance companies should be allowed to make profit or have profit limited on basic plans.
- If they have a loss, are we obligated to make up the loss?
- Maribeth Healey asked that it be noted on the record that the Committee did not meet its objective on cost containment.
- **Recommendation 5 on page 13** – Relates to "higher standards of immunity from litigation." Has not been voted on nor fully debated. Suggestion of a liability fund, or other options to recommend that protect patients more than limiting ability to sue.
- Staff related that on page 43, more detailed recommendation, discussion includes acknowledgement that there was inadequate time to form a recommendation in this area.
- Other options need to be suggested.

Motion to remove Recommendation 5 on pages 13 and 43 on the creation of a professional liability fund as part of these recommendations.

Discussion

- Support for motion against recommending any immunity from litigation. Needs more study and deliberation.
- Concern expressed for physicians with no claims paying high premiums. Suggestion that it would not get to trial if the physician follows evidenced-based procedures.
- Reiteration that it is a recommendation that takes away patient rights.
- Issue of immunity discussed.

Board met

Friendly amendment to retain discussion with suggestion of protections for providers and patients.

Amendment Accepted.

Call for the Question. Motion carries 9-4.

Motion to approve the report as amended is seconded. **Motion passed 10-1???**

- Request to see minority report. Report will be circulated.

Chair Stenson **VIII** **Public Testimony**

- **Dr. Gina Nichol, Director of Association of Community Mental Health**, **Addictions and Development Disabilities programs and member of HIIAC**. Complimented the Committee on their process while being faced with short timeline. Suggestion to include in report: (1) statement referring to world class organization needs to be broader and stronger, it is a culture change; and 2) on page 14 and primary care could add that ½ of the people who die from smoking have a serious mental illness (provided supporting information).
  - Stronger emphasis on integrating mental health, addictions and dental care.
  - Related that jails are the largest health provider for mental health.
  - Related information on SB 1087.

- Agrees that report needs more on cost containment and cost shifting.
- Testifies to the importance of safety net clinics.

- **Mallen Kear, Portland**, challenged some assertions relating to minority report. Asserts that there are public-private health systems in other countries as opposed to a single-payer system. States that reforms can be made on a state-by-state basis.

- **Don Klosterman, citizen**, related that the report could be strengthend by identifying essential recommendations that would give greater guidance. Support for strong state audit system.

Submitted By:
Paula Hird

Reviewed By:

Exhibit Materials

1. **Agenda**
2. **Delivery Systems meeting minutes of 05/13/08.**
3. **Member Comments**
4. **Delivery Recommendations with no Quality Institute report**

Oregon Health Fund Board
Delivery System Committee Charter
Approved by OHFB on :

I. Objective

The Delivery System Committee ("Committee") is chartered to provide the Board with policy recommendations to create high-performing health systems in Oregon that produce optimal value through the provision of high quality, timely, efficient, effective, and safe health care.

The Committee's recommendation will serve as a cornerstone to the success of the Board's final report. The work of the Committee is framed by several principles and goals outlined in SB 329:

- *Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcomes.*
- *Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability….*
- *Use proven models of health care benefits, service delivery and payments that control costs and overutilization….*
- *Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.*
- *Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year….*

The Board seeks, through the work of the Committee, more effective and efficient models of health care delivery that will address the health needs of all Oregonians through accountable health plans and other entities.

Bold and creative thinking is encouraged!

II. Scope

A. Assumptions:

In addition to the Board's *"Design Principles & Assumptions"* (attached), the Committee's work should be framed by the following assumptions:

1. While new revenue will be needed in the intermediate term to provide coverage to the currently uninsured, improving the performance of Oregon's delivery systems should provide opportunity to recapture or redeploy resources with consequent reduction in the annual rates of increase in health care costs.

2. The Committee's recommendations on system changes and cost containing strategies should apply to Oregon's delivery systems broadly, not solely to programs for the uninsured.

3. Proposed strategies for containing the rate of health care cost increases should include estimates of "savings" over a defined time period. Such projections will be used by the Finance Committee in the development of overall revenue requirements.

4. The following concepts are of priority interest to the Board:

- **Primary Care**

  Revitalizing primary care models to improve the capacity for and outcomes from preventive and chronic care services.

- **Managing Chronic Disease**

  Strategies for comprehensive, coordinated and sustained clinical management of the chronic diseases that significantly impact overall health care expenditures.

- **New Reimbursement Models**

  Strategies that move from fee-for-encounter (service) to financial incentives/rewards for providers who produce clinical outcomes that meet or exceed widely accepted standards of care.

- **Health Information Technology**

  Public policies and public-private collaborations that will increase the rate of diffusion and use health information technologies (e.g. electronic health records, registries, etc.) and ensure the interoperability of such technologies.

- **Information Transparency**

  Recommendations for a model Oregon Quality Institute that collects, measures and reports information on the performance of health care delivery systems including, but not limited to clinical quality and efficiency indicators. (See Oregon Quality Institute Work Group, below)

- **New Clinical Technologies**

  Recommendations to assure that the "added value" of new clinical technologies is broadly understood and that avoid inappropriate diffusion and utilization.

- **Public Health & Prevention**

  Strategies to develop, implement, sustain, evaluate and finance public health and public-private programs that target critical population health issues such as the obesity in Oregon's population.

- **End-of-Life Care**

Recommendations to improve end-of-life care that promote information about care options and advance directives, improve provider awareness of patient preferences and assure services for dignified care.

Note: The preceding list is not intended to limit the Committee's scope of investigation or recommendations.

B. Criteria:

The Committee should utilize the following criteria to evaluate proposed recommendations:

1. Does the recommendation improve the "value equation"? [Cost / Quality]

2. Does the recommendation contain the rate of growth of health care costs? Can the impact be measured objectively over time?

3. What is the anticipated timeframe for implementation?

- Short term? (1 to 2 years)
- Intermediate term? (3 to 5 years)
- Long term? (5+ years)

4. Does the recommendation require public policy action (statutory or regulatory)? Are the "politics" for such action: Favorable? Mixed? Unfavorable? Unknown?

5. Is voluntary collaboration among purchasers, providers, payers or consumers required to implement the recommendation? What is the "readiness" of key stakeholder groups to support such an effort?

C. Deliverables:

The Board anticipates receiving 5 to 10 recommendations from the Committee that address, in a strategic manner, the development of high-performing, value-producing health care systems. The recommendations may be prioritized.

Each recommendation should include, at minimum:

- A complete description of the recommended strategy and its intended objective(s).
- The method(s) for measuring the impact of the strategy over time.
- Estimates of "savings" achieved over a defined period of time through containing the rate of cost increases.
- The estimated timeframe for implementation with key milestones and risks.
- The impact of the strategy on key stakeholders.
- Reference citations to clinical or health services research relied upon in developing the recommendation.

III. Timing

The Committee will deliver its recommendations to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Dick Stenson, Chair	Tuality Healthcare	Hillsboro
Maribeth Healey, Vice-Chair	Advocate	Clackamas
Doug Walta, MD, Vice-Chair	Physician	Portland
Vanetta Abdellatif	Multnomah Co. Health Department , Health Policy Commission (HPC)	Portland
Mitch Anderson	Benton County Mental Health	Corvallis
Tina Castanares, MD	Physician, Safety Net Clinic	Hood River
David Ford	CareOregon	Portland
Vickie Gates	Consultant, HPC	Lake Oswego
William Humbert	Retired Firefighter	Gresham
Dale Johnson	Blount International, Inc.	Portland
Carolyn Kohn	Community Advocate	Grants Pass
Diane Lovell	AFSCME, PEBB Chair	Canby
Bart McMullan, MD	Regence BlueCross BlueShield of OR	Portland
Stefan Ostrach	Teamsters, Local 206	Eugene
Ken Provencher	PacificSource Health Plans	Eugene
Lillian Shirley, RN	Multnomah Co. Health Department	Portland
Mike Shirtcliff, DMD	Advantage Dental Plan, Inc.	Redmond
Charlie Tragesser	Polar Systems, Inc.	Lake Oswego
Rick Wopat, MD	Samaritan Health Services, HPC	Corvallis

V. Staff Resources

- Jeanene Smith, Administrator, Office for Oregon Health Policy and Research (OHPR) - Jeanene.Smith@state.or.us; 503-373-1625 (Lead staff)
- Tina Edlund, Deputy Administrator, OHPR – Tina.D.Edlund@state.or.us; 503-373-1848
- Ilana Weinbaum, Policy Analyst, OHPR – Ilana.Weinbaum@state.or.us; 503-373-2176
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574

Oregon Quality Institute Work Group

Scope

In order to achieve a high-performing health care delivery system and contain cost increases, the State must work with providers, purchasers, payers and individuals to improve quality and transparency. The Oregon Quality Institute ("Institute") work group will make recommendations on the State's role in building on existing efforts to develop a public-private entity to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The work group's recommendations will address:

- How should an Institute be organized and governed? How will it coordinate with individual stakeholder efforts and support collaboration?
- How should an Institute be funded in the short and long term?
- How should cost and quality data be collected and stored in a central location?
- What state regulations should be examined for opportunities to increase efficiency and reduce administrative cost?
- How can an Institute foster provider capacity to collect data and use it for improvement?
- What dissemination formats will make information useful to a broad range of audiences?
- How should an Institute address issues of legal discovery and liability?
- What role can an Institute play in engaging Oregonians to use available data when making health care decisions?
- How can the State encourage more effective and coordinated value-based purchasing? How can the State strengthen its own efforts to use value-based purchasing to improve delivery of care for state employees and those served by the Oregon Health Plan?

Timing

The work group will deliver its analysis and findings to the Delivery Committee for review by February 2008.

Work Group Membership

The Institute work group will be comprised of select members of the Delivery Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the work group.

Oregon Health Fund Board
Eligibility & Enrollment Committee
Approved by OHFB on :

I. Objective

The Eligibility and Enrollment Committee is chartered to develop recommendations for the eligibility requirements and enrollment procedures for the Oregon Health Fund program to the Oregon Health Fund Board. The work will be guided by the Board's "*Design Principles & Assumptions*".

II. Scope

The Eligibility and Enrollment Committee will focus its study of strategies to Eligibility requirements, including:

1) Affordability: public subsidies of premiums and other costs associated with the program that ensure program affordability at all incomes for individuals and sustainability for the state;
2) Enrollment Procedures: streamlined procedures, including: a standardized application process, application assistance, requirements to demonstrate Oregon residency, retroactive eligibility, waiting periods, preexisting condition limitations, other administrative requirements for enrollment;
3) Disenrollment: standards for disenrollment and changing enrollment in Accountable Health Plan;
4) Outreach: an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and program's eligibility requirements and enrollment procedures; and,
5) ESI: process for allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

III. Timing

The Committee will provide its recommendation(s) to the Benefits Committee on public subsidies and affordability no later than January 15, 2008 and all other recommendation(s) to the Board for review and public comment no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Ellen Lowe, Chair	Advocate and Public Policy Consultant	Portland
Jim Russell, Vice-Chair	MidValley Behavioral Care	Salem
Robert Bach	Medicaid Advisory Committee (MAC)	Portland
Jane Baumgarten	Retired	Coos Bay
Dean Kortge	Pacific Benefits Consultants	Eugene
Felisa Hagins	SEIU Local 49	Portland
Noelle Lyda	Ed Clark Insurance Inc.	Salem

CJ McLeod	The ODS Companies	Portland
John Mullin	Oregon Law Center	Portland
Bill Murray	Doctors of Oregon Coast South	Coos Bay
Ellen Pinney	Oregon Health Action Campaign	Corbett/Salem
Susan Rasmussen	Kaiser Permanente	Portland
Carole Romm	Central City Concern, MAC	Portland
Ann Turner, MD	Virginia Garcia Health Center	Cornelius

V. Staff Resources

- Tina Edlund, Deputy Administrator, Office for Oregon Health Policy and Research (OHPR) - Tina.D.Edlund@state.or.us; 503-373-1848 (Lead Staff)
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- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1608
- Tina Huntley, Assistant, OHPR – Tina.Huntley@state.or.us; 503-373-1629

Oregon Health Fund Board
Federal Laws Committee Charter
Approved by OHFB on :

I. Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

II. Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Healthy Oregon Act including, but not limited to, the following:

1) Medicaid requirements such as eligibility categories and household income limits and Medicaid waivers;
2) Medicare policies "that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate."
    - The Committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access.
    - The Committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.
3) Employment Retirement Income Security Act (ERISA) requirements and the extent to which it is clear what state action is permissible without further decisions by the federal courts;
4) Federal tax code policies "regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;"
5) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations "that make the delivery of health care more costly and less efficient" and EMTALA waivers; and
6) The Health Insurance Portability and Accountability Act (HIPAA) and any other area of federal policy that inhibit Oregon's ability to move forward with health care reform efforts.

III. Timing

In December 2007 and January 2008, the Committee will solicit written comments from the public and key stakeholders on the impact of federal policy on Oregon's reform efforts and recommendations to remove barriers to these efforts. From January – April

2008, the Committee will hold a series of meetings to include panels of stakeholders to present on and discuss selected areas of federal policy. The results of these meetings will inform the Committee's findings and recommendations.

The draft report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation.

Although SB 329 requires this report no later than July 31, 2008, the Board will request the Oregon Legislature's approval to change the due date to October 1, 2008. This change will allow the report of this Committee to be presented in a series of public hearings during the summer of 2008 along with the Board's draft comprehensive plan. Public comments gathered at these meetings will be incorporated into the final report. Whether or not the deadline change is approved, the Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

IV. Committee Membership

Name	Affiliation	City
Frank Baumeister, Chair	Physician	Portland
Ellen Gradison, Vice Chair	Oregon Law Center	Corvallis
Mike Bonetto	ZoomCare	Bend
Chris Bouneff	DePaul Treatment Centers	Portland
Michael Huntington, MD	Retired Physician, Archimedes	Corvallis
Julia James	Consultant	Bend
Mallen Kear, RN	Retired Nurse, Archimedes	Portland
Sharon Morris	Health Care Administrator (retired)	Grants Pass
Larry Mullins, DHA	Samaritan Health Services	Corvallis
Nicola Pinson	OR Primary Care Association	Portland
Tom Reardon, MD	Retired Physician	Portland

V. Staff Resources

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- Erin Fair, MPH, Law Student Intern, Office for Oregon Health Policy and Research – EMAIL, PHONE
- Judy Morrow, Assistant, Office for Oregon Health Policy and Research and Oregon Health Fund Board – Judy.Morrow@state.or.us; 503.373.2275

Oregon Health Fund Board
Health Equities Committee
Approved by OHFB on :

I. Objective

The Health Equities Committee ("Committee") is chartered to develop multicultural strategies for program eligibility and enrollment procedures and policy recommendations to reduce health disparities through delivery system reform and benefit design in the Oregon Health Fund program. Guided by the Board's *"Design Principles & Assumptions"*, the work of the Committee will be submitted directly to the Oregon Health Fund Board (OHFB) as well as integrated into the work of other OHFB committees.

II. Scope

The Committee will focus its study on strategies to reduce health disparities in Oregon, including but not limited to:

1. Providing the Eligibility & Enrollment Committee with recommendations concerning:
    - Best practices for outreach in communities of color, homeless adults and youth, and with individuals who live in geographic isolation.
    - Strategies to reduce disparities in insurance status by decreasing barriers to enrollment and streamlining enrollment policies & practices.
2. Providing the Delivery System Committee with recommendations concerning reducing health disparities in Oregon. Recommendations may include:
    - Elements of the Medical Home model that reduce health disparities and provide culturally competent care.
    - Financial incentives for providers to reduce targeted health disparities and improve quality care.
    - A plan to increase collection of health-related data for people of color and other under-represented populations using techniques that are culturally sensitive and accurate.
    - Provider workforce issues such as recruitment of minority and rural providers, retention, and cultural-competence training.
    - Methods to empower and incentivize individuals to make healthy lifestyle choices.
    - Reimbursement options for health promotion activities that occur outside of the traditional healthcare delivery system.
3. Providing the Benefits Committee with recommendations concerning benefit designs that support the health of women, minorities, and other vulnerable populations including:

- Benefits related to women's health and benefit designs that target women of childbearing age.
- An emphasis on reducing health disparities in developing a benefit package of essential health services.
- Ensuring an affordable benefit package that promotes the health of individuals who have physical or mental health disabilities.

III. Timing

The Committee will provide its recommendation(s) to the Eligibility and Enrollment Committee on no later than January 15, 2008, to the Delivery Committee no later than February 15, 2008, to the Benefits Committee no later than March 15, 2008 and all other recommendation(s) to the Board no later than April 30, 2008.

IV. Committee Membership

Name	Affiliation	City
Ella Booth, Ph.D., Chair	Oregon Health & Science University (OHSU)	Portland
Joe Finkbonner Vice Chair	Northwest Portland Indian Health Board	Portland
Tricia Tillman, MPH, Vice Chair	Multnomah County Health Department	Portland
Michelle Berlin, MD, MPH	Center of Excellence in Women's Health, OHSU	Portland
Ed Blackburn	Central City Concern	Portland
Bruce Bliatout, Ph.D.,	Multnomah County Health Department	Portland
John Duke, MBA	Outside-In Homeless Youth Clinic	Portland
Honora Englander, MD	OHSU Division of Hospital Medicine	Portland
Scott Ekblad	Office of Rural Health, OHSU	Portland
Yves LeFranc, MD	Legacy Health Systems	Portland
Holden Leung, MSW	Asian Health and Service Center	Portland
Jackie Mercer	NARA	Portland
Maria Michalczyk, RN, MA,	Healthcare Interpreter Training program, Portland Community College	Portland
Melinda Muller, MD	Legacy Health Systems	Portland
Laurie Powers, Ph.D.	Portland State University, Reg. Research Institute	Portland
Noelle Wiggins	Multnomah County Health Department	Portland

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- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1632
- Shawna Kennedy-Walters, Office Specialist, OHPR – Shawna.Kennedy-Walters@state.or.us; 503-373-1598

A Comprehensive Plan for Reform: Design Principles & Assumptions

Design Principles

I. Optimize health: Wellness, prevention, early intervention & chronic disease management are strategic priorities.

II. Effective markets provide useful information to producers & purchasers.

III. The responsibility & accountability for the financing and delivery of health care is shared by all Oregonians.

IV. Oregon's health care financing & delivery system must be designed & operated for long-term sustainability.

V. Financial barriers to affordable coverage are removed.

VI. Reforms will build on the foundational elements of the current system.

Design Assumptions

A. Reforms in coverage, combined with changes in the organization, management and reimbursement of the delivery system can improve health outcomes & contain the historic pattern of annual cost increases in health care. **[BETTER OUTCOMES & ↓ COST GROWTH]**

B. Providers, payers & purchasers will collaborate to implement a comprehensive & transparent reporting system to monitor the value (efficiency, quality, safety & consumer satisfaction) provided by health care providers & payers. **[INFORMATION → ↑ QUALITY & EFFICIENCY]**

C. All Oregonians will be required to have health insurance coverage. Reforms will ensure that affordable coverage options are available. **[INDIVIDUAL MANDATE]**

D. Employers not providing employee coverage will be required to contribute, in some manner, to the costs of the health care system. **[PLAY OR PAY]**

E. Public financing will be broad-based, equitable & sustainable. **[FISCALLY FAIR & RESPONSIBLE]**

F. The individual (non-group) insurance market will require new rules to ensure a choice of coverage that is efficient and sustainable. **[A NEW MARKET = NEW RULES]**

G. Public subsidies will be available to assist defined populations to obtain affordable coverage. **[ASSIST THOSE IN NEED]**

H. - Employer-sponsored coverage will continue to be the primary source of coverage for most Oregonians.
- A FHIAP-like program will serve Oregonians within defined income levels through premium subsidies.
- The Oregon Health Plan (Plus & Standard) will serve Oregonians below defined income levels.

I. New revenue (tax) options will be required

OREGON HEALTH FUND BOARD

A Comprehensive Plan for Reform: Design Principles and Assumptions

Approved by OHFB _____

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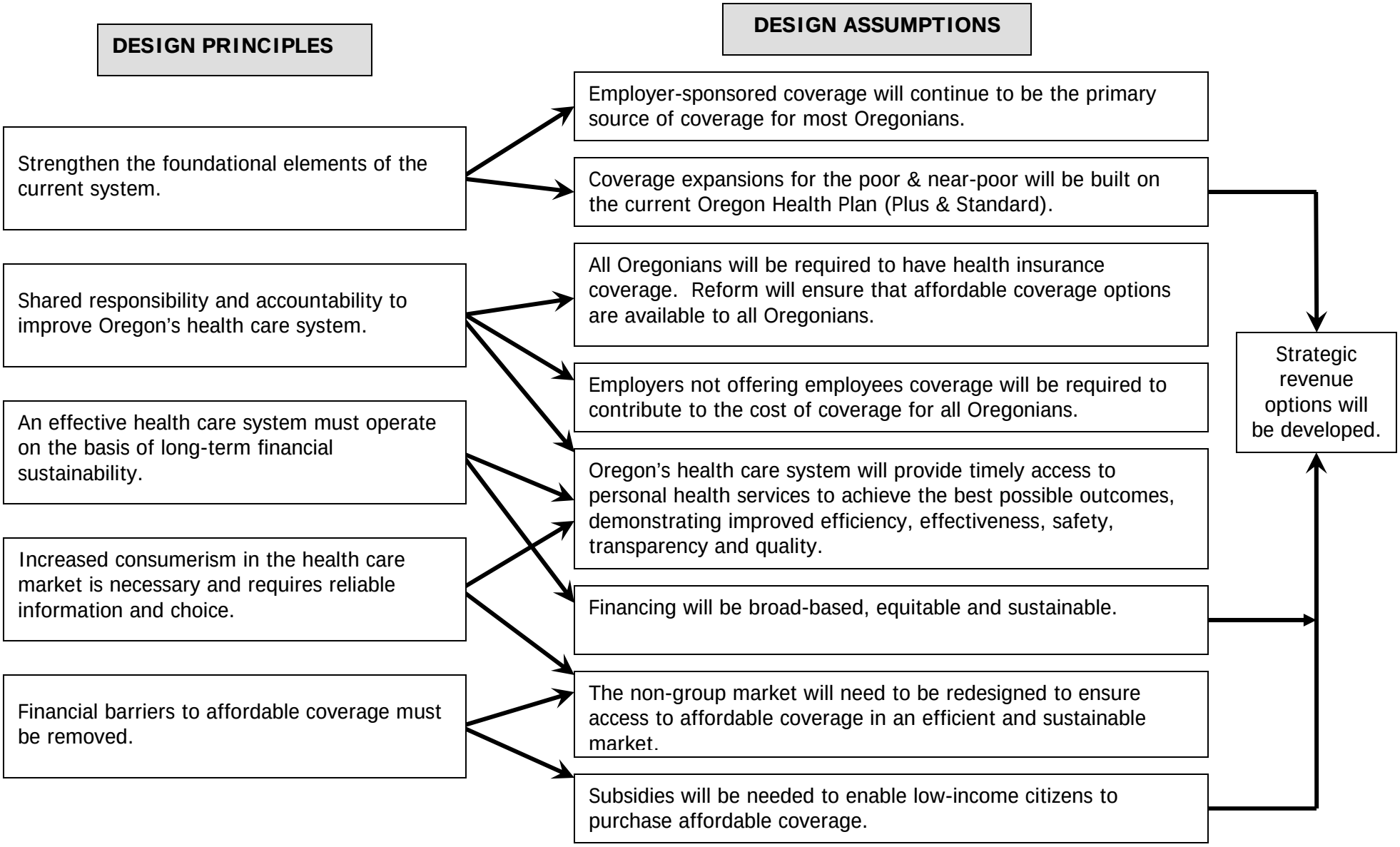

The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act

December 2007

Office for Oregon Health Policy and Research

The Medical Home Model of Primary Care: Implications for the Healthy Oregon Act

Prepared by:

Rob Strenger, MD, MPH, Oregon Health and Science University Family Medicine, with updates from Office for Oregon Health Policy and Research staff

Received by:

The Office for Oregon Health Policy and Research

If you have any questions, or if you need this material in an alternate format, please call (503) 378-2422

Office for Oregon Health Policy and Research
http://egov.oregon.gov/DAS/OHPPR/

December 2007

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Special thanks to those who provided background information for this report:

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Elizabeth Steiner, M.D. – Oregon Academy of Family Physicians
Jean Thorne – Public Employees' Benefits Board
Rick Wopat, M.D. - Samaritan Health System

Contents

Executive Summary

The Healthy Oregon Act of 2007 establishes the Oregon Health Fund Board (OHFB) and charges it with developing a comprehensive health care reform plan for the state. The Act directs the Board to reform the current health care system so that it covers all Oregonians, while improving equity, efficiency, safety, effectiveness, quality and affordability of care. The bill specifically calls for a revitalization of primary care, with an increased focus on prevention, wellness, and disease management and requires that the Board explore proposals to expand access to primary care medical homes.

While there are significant problems with the entire health care system in Oregon, there are specific challenges in the primary care sector that must be addressed by any effort to improve health care delivery. A primary care workforce shortage, as well as decreasing access to primary care providers, makes it difficult for many Oregonians to seek regular primary care and receive recommended primary care and preventative services. In addition, primary care physicians are facing overwhelming workloads, but are paid substantially less than specialists. Evidence shows that an effort to overcome these challenges and strengthen the primary care core in Oregon can lead to a system that better meets the needs of the population. Research has demonstrated better health outcomes and lower per capita costs for states and countries with strong primary care systems.

Many health care organizations and professional associations see the primary care medical home as a vital component of primary care renewal. While a number of slightly different definitions have been proposed, the primary care medical home can generally be characterized as a primary care practice which provides the following to its patients: a continuous relationship with a physician; a multidisciplinary team that is collectively responsible for providing for a patient's longitudinal health needs and making appropriate referrals to other providers; coordination and integration with other providers, as well as public health and other community services, supported by health information technology; an expanded focus on quality and safety; and enhanced access through extended hours, open scheduling, and/or email or phone visits. While there have been few large-scale demonstrations of medical homes, a growing evidence base demonstrates that these core features can lead to higher patient satisfaction, better health outcomes, and lower overall costs.

One of the major barriers to the implementation of the medical home model is the current reimbursement structure. Most physicians are currently paid on a fee-for-service basis, which rewards providers for higher volume rather than for using resources effectively to maximize health. In addition, providers are currently reimbursed only for office visits and cannot bill for email or phone communication with patients or for providing care coordination services. A number of different payment mechanisms have been proposed to encourage primary care providers to become more patient-centered and to provide the resources that practices need to transform into true medical homes. In order to more closely align reimbursement policies with the goals of the medical home, funding mechanisms must be transparent, provide services for coordination of care, improve access and care management, reward providers for improving health outcomes and

quality and decreasing cost; and must support transitional and start-up costs associated with transformation, including investments in health information technology. A number of payment models have been proposed to support the medical home, including pay-for-performance and pay-for-process, comprehensive prospective payments for providing medical home services, fee-for-service reimbursement for medical home services, one-time grants and specific support for case management, and disease management services. Most organizations have agreed that effective payment reform will need to combine traditional fee-for-service payments with bundled payments for providing medical home services and a bonus based on performance.

There are a number of key systems and cultural and policy barriers that must be addressed in any effort to transform primary care practices across the state into patient-centered primary care medical homes. These challenges include inadequate funding of primary care, dilution of financial incentives across purchaser organizations, an absence of a common vision among primary care providers, premature expectations of progress, habituation to misaligned incentives, resistance to change, and a public that is accustomed to an open health system. Fortunately, there are many organizations in both the private and public health care sectors in Oregon and across the nation that have invested resources in medical home initiatives and demonstration projects to learn how the medical home model can be implemented in real world settings. Many of these efforts are described in the ***Medical Home Initiatives and Demonstration Projects*** section of the full paper. These efforts have resulted in important tools and lessons that can inform the work of the Oregon Health Fund Board.

In its efforts to encourage system changes and move towards providing a primary care medical home for all Oregonians, the Oregon Health Fund Board should consider the following steps:

#1 – ***Encourage and reward efforts to inform providers of the need for primary care reform and the characteristics of a patient-centered medical home.***

#2 – ***Develop a standard definition of medical home and standard measures to determine whether primary care providers meet this definition. This definition should be broad enough to allow for innovation and encompass various models that provide medical home services to their patients.***

#3 – ***Coordinate lessons from current demonstrations of medical home models in Oregon and encourage more demonstrations.***

#4 – ***Consider specific support for demonstration projects targeted at small practices and rural providers.***

#5 – ***Consider specific support for demonstration projects targeted at high need or vulnerable populations.***

#6 – ***Develop a sustainable financing model that supports medical home services.***

#7 – ***Partner with other purchasers of health care to develop a uniform set of standards or common measures of clinical performance outcomes.***

#8 – ***Consider how best to provide adequate funding for technical support, education, and dissemination of best practices to support patient-centered primary care practice re-design.***

Introduction

Passed in 2007, the Healthy Oregon Act establishes the Oregon Health Fund Board (OHFB) and tasks it with developing "a comprehensive plan" for health reform in Oregon.[1] The Act creates the Oregon Health Fund Program, the goal of which is to provide Oregonians with universal access to high-quality health care while containing system-wide costs. Meeting the goals outlined in the Healthy Oregon Act will require an efficient and effective system for delivering primary care. One way to accomplish this, as specified by the Act, will be to require that every participant in the new program has a "primary care medical home".

The aim of this paper is to provide the OHFB and the public with information on the current status of the primary care system in Oregon as well as an overview of the role for medical homes in this environment. It looks within Oregon, as well as to other states and coalitions, to examine the defining characteristics of primary care homes and draw lessons from efforts to integrate medical home programs into delivery systems. Medical homes will likely play a large role in the new Oregon Health Fund Program, and this report offers key opportunities for the OHFB to consider as the group develops a plan for delivery system reform.

The Primary Care System Envisioned by the Healthy Oregon Act

The ambitious goals of the Healthy Oregon Act will require significant changes in the financing and delivery of health care in Oregon. The Act lays out a series of core principles on which the Oregon Health Fund Program must be based, which include "expanding access, equity, education, efficiency, economic sustainability, aligned financial incentives, wellness, community based care, and coordination of care (Sect 3, 1-15)". The bill calls for a greater emphasis on preventative care, chronic disease management, health promotion and wellness, which are hallmark features of a strong primary care core. Furthermore, the Act specifies that all participants in the Oregon Health Fund Program should have a primary care home and that payment incentives must be restructured to reward more effective and efficient provision of care. Given these requirements, delivery system redesign must begin with a renewal of the primary care system, which includes efforts to provide more Oregonians with primary care medical homes.

Challenges Facing the Primary Care System

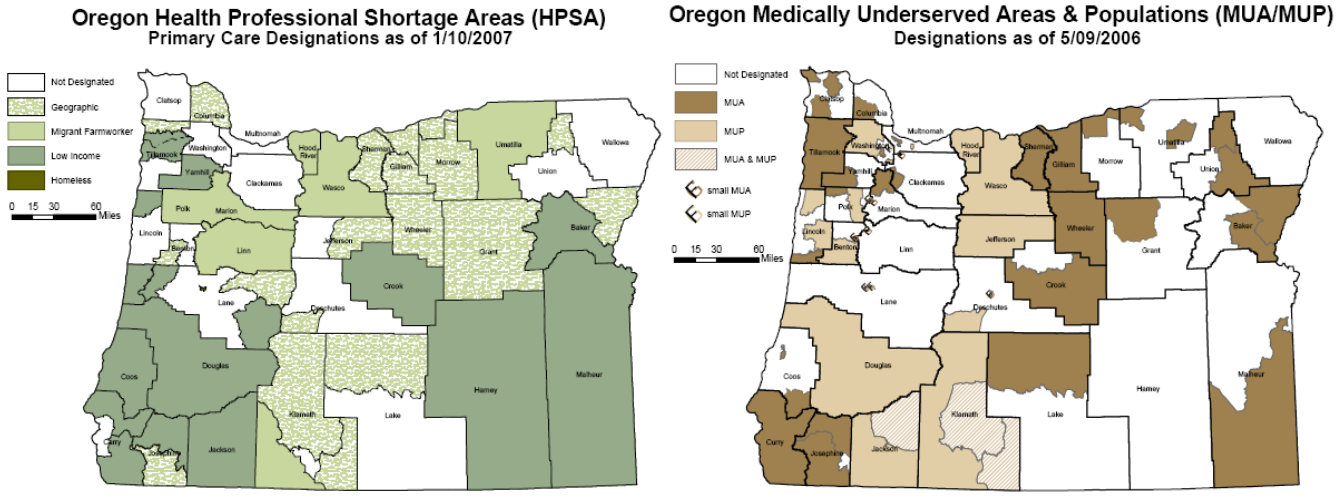
By many accounts, the medical system in Oregon is not sustainable. In its *Road Map for Health Care Reform*, the Oregon Health Policy Commission found that the number of uninsured Oregonians is rising; health care costs are increasing rapidly; service delivery is fragmented; and the current system fails to consistently provide high-quality, prevention-oriented health care to Oregonians.[2]

[1] Enrolled Senate Bill 329, The Healthy Oregon Act. June 2007.
[2] Oregon Health Policy Commission. Road Map for Health Care Reform. March 2007.

While the whole health care system is not performing adequately, there are many unique problems in the primary care system that prevent even those with health insurance and a regular doctor from consistently receiving high-quality, cost-effective care.

Workforce shortage in primary care – There are 63 primary care physicians for every 100,000 residents in Oregon, representing about one-third of the physician workforce.[3] If these physicians were ideally distributed and all worked a full-time clinical schedule, this would result in a panel size of about 1,600 patients per primary care physician. Proposals for primary care reform suggest a panel size of between 1,000-2,000 patients per full time provider, with smaller panel sizes when physicians provide care to many complex patients with chronic conditions.[4,5] Given the current numbers of physicians and distribution of primary care providers, an ideal panel size is unattainable in much of the state. Consequently, significant portions of the Oregon population live in a primary care Health Professional Shortage Area (defined as a local population to primary care physician ratio of greater than 3,500:1) or are "medically underserved" (Figure 1).[6]

Figure 1: Primary Care Shortage Areas and Underserved Populations in Oregon



Decreasing access to primary care providers – As the shortage of primary care physicians becomes more pronounced, patient access to primary care providers suffers. According to a national survey of patients' experiences, the percentage of patients who could not schedule timely appointments with their physician increased between 1997 and 2001. During the same period, patients also reported increased problems reaching their medical provider on the phone and being able to get to their physician's office when it

[3] Health Resources and Services Administration. State Health Workforce Profiles: Oregon. 2000.
[4] Gorrol AH, Berenson RA, Schoenbaum SC, et al. Fundamental Reform of Payment for Adult Primary Care: Comprehensive Payment for Comprehensive Care. Journal of General Internal Medicine. 2007;22(3):410-415.
[5] Labby D. Personal communication about the CareOregon primary care renewal demonstration project.
[6] Oregon Division of Health System Planning. Charts compiled using data from HRSA.

was open.[7] Access is further hindered by an increasing number of primary care practices that are closed to new patients, most often those covered through Medicare, Medicaid or Workers' Compensation. In 2006, 18.1% of Oregon's family or general medicine practices reported they were completely closed to new Medicare patients, 25.6% reported they were closed to new Workers' Compensation patients, and 14.9% reported they were closed to new Medicaid patients.[8]

Overwhelming workload for primary care providers – In the last several decades, evidence-based guidelines for management of chronic diseases and preventive care have generated an ever-increasing and complex workload for primary care providers.[9] Primary care providers do not have the resources and support they need to provide high-quality care in this new environment. For example, a recent study found that primary care providers would have to spend 10.6 hours per day (27% more time than is currently available on average for patient care) just to provide a 2,500 patient panel with all of the recommended care for ten chronic conditions.[10]

Needed care falling through the cracks – Given this overwhelming workload, it is not surprising that the quality of primary care is not ideal. On average, patients receive about 55% of the health care recommended by current guidelines.[11] Another study found that patients visiting their family physician were up to date on only 55% of screening tests, 24% of immunizations, and 9% of habit-related health counseling.[12]

Inadequate and inequitable reimbursement – Despite the growing and complex responsibilities associated with providing primary care, primary care physicians are paid substantially less than other physicians and have slower rates of salary growth despite similar work hours. The median income of primary care physicians is roughly half that of specialists, and the income gap is widening.[13] This income differential is cited as one of the reasons that fewer and fewer medical students are choosing to go into general primary care.[14] Furthermore, the majority of providers in the United States are paid on a fee-for-service basis, creating a system that rewards acute treatment of disease, rather

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[7] Strunk BC, Cunningham PJ. Treading Water: Americans' Access to Needed Medical Care, 1997-2001. Washington, DC, Center for Studying Health System Change. 2002.
[8] Oregon Physician Workforce Survey, Office for Oregon Health Policy and Research. May 2007.
[9] Bodenheimer T, Grumbach K. Improving Primary Care: Strategies and Tools for a Better Practice. Chapter 1: The Primary Care Home. McGraw Hill Companies Inc. 2007.
[10] Ostbye T, Yarnall KS, Krause KM, et al. Is There Time for Management of Patients with Chronic Disease in Primary Care? Annals of Family Medicine. 2003;1:149-155.
[11] Recommended health care includes chronic care, acute care and preventive care. McGlynn EA, Asch SM, Adams J, et al. The Quality of Health Care Delivered to Adults in the United States. New England Journal of Medicine. 2003;6:63-71.
[12] Stange KC, Flocke SA, Goodwin MA, et al. Direct Observation of Rates of Preventive Service Delivery in Community Family Practice. Preventive Medicine. 2000;31:167-176.
[13] Bodenheimer T, Berenson RA, Rudolf P. The Primary Care-Specialty Income Gap: Why it Matters. Annals of Internal Medicine. 2007;146(4):301-307.
[14] American College of Physicians. The Impending Collapse of Primary Care Medicine and Its Implications for the State of the Nation's Health Care. January 2006. Available: http://www.acponline.org/hpp/statehc06_1.pdf

than efforts to keep patients healthy, prevent costly diseases, and effectively manage chronic conditions.

Primary care providers are the backbone of the health care system. About one-third of physicians in Oregon practice primary care and they account for about half of all physician visits.[3,15] If adequately supported, these providers can deliver the majority of health care required by their patients in a low-cost, efficient way. However, if system changes are not implemented, the primary care system will remain unable to achieve these goals.

If health reform is to create sustainable change, it must include the primary care system. One model for primary care reform is the medical home model included in the Healthy Oregon Act. The Oregon Academy of Family Physicians, the Oregon Primary Care Association, and a number of national groups have endorsed this model.[16] The Oregon Health Policy Commission and the Public Employees' Benefits Board have also proposed moving towards the medical home model.[2]

The Medical Home Model of Primary Care

The concept of a "medical home" was initially proposed by the American Academy of Pediatrics in 1967 and has evolved over the last several decades. As health care has grown increasingly complex, fragmented, and disorganized, the medical home model represents a strategy for strengthening the primary care system's ability to deliver care that is patient-centered, evidence-based, and coordinated.[17] In short, a medical home is a regular source of medical care that delivers the services needed to achieve optimal individual and population health.

Many professional organizations have developed definitions that specify the characteristics of a medical home (see Appendix A). At the beginning of 2007, the four largest professional associations representing primary care practitioners, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA), agreed on a set of core features of a "Patient-Centered Medical Home" model. These groups have joined with employers, consumer advocacy and other stakeholder groups to form the Patient-Centered Primary Care Collaborative to promote this model nationwide.[18] The core features include the following:

- ***Personal Physician –*** Every patient has an established and continuous relationship with a personal physician.

[15] Graham R, Roberts RG, Ostergaard DJ, et al. Family Practice in the United States. JAMA. 2002;288:1097-1101.
[16] American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. Joint Principles of the Patient-Centered Medical Home. March 2007.
[17] American College of Physicians. The Advanced Medical Home: A Patient-Centered, Physician-Guided Model of Health Care. ACP Policy Monograph; 2006.
[18] Patient-Centered Primary Care Collaborative. http://www.pcpcc.net

- ***Physician Directed Medical Practice*** **-** Physician directs a coherent team of providers who are collectively responsible for the patient's longitudinal health needs. Roles within the team are assigned to maximize the efficient use of resources and responsiveness to patient needs.
- ***Whole Person Orientation –*** Medical home assumes responsibility for providing for all of the patient's health care needs, including acute care, preventative, disease management services, and end of life care. The medical home provides direct care when possible and arranges for appropriate referrals to other providers.
- ***Coordinated and/or Integrated Care*** **-** Care received from the medical home is coordinated/integrated with care received from other providers and organizations, as well as with services provided within a patient's community, including public health, mental health, and behavioral health services. Coordination allows patients to receive appropriate care when and where they need it. Registries, information technology, information exchange, and other resources are utilized by the medical home to establish and facilitate coordination.
- ***Quality and Safety –*** Medical homes focus on quality improvement and safety, through physician participation in performance measurement and improvement efforts, use of clinical decision-support technology, and clinical standards and guidelines built on evidence-based medicine. Patients participate in shared decision-making, quality improvement efforts and practice evaluation.
- ***Enhanced Access*** – Patient access to both office-based and non-office based care is expanded through mechanisms such as longer hours, group visits, open scheduling, phone and email visits, and other web-based communication. [16, 19]

Many primary care practices currently strive to provide their patients with a regular source of care and at least some of the "medical home" set of services; however, very few providers are able to offer their patients a true patient-centered medical home. For instance, a recent national patient survey found that about 80% of patients have a regular source of care, but only 27% report that their provider meets four indicators of improved access to care, a necessary component of the medical home.[20] Oregon has a strong primary care base on which to build, but those involved in all aspects of health care delivery will need to rethink the way care is delivered in order for reforms to successfully provide all Oregonians with medical homes.

[19] Robert Graham Center. The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change. November 2007.
[20] Beal AC, Doty MM, Hernandez SE, et al. Closing the Divide: How Medical Homes Promote Equity in Health Care. The Commonwealth Fund. June 2007.

Benefits of the Medical Home

There is a substantial body of evidence supporting the value of a health care system built around a robust primary care core:

- States with a higher percentage of primary care providers have better health outcomes on a variety of measures while areas with more specialists have higher per capita costs and lower quality.[21,22,23]
- Countries with a strong primary care system have better health outcomes and lower per-capita costs than countries with weak primary care.[24]
- Improved access to primary care results in decreased hospitalization rates for ambulatory care sensitive conditions.[25,26]
- Patients with primary care physicians as their regular source of care have lower health care costs than those who list specialists as their regular source of care.[27]

The abundance and diversity of evidence on the positive effect of primary care lends support to the theory that any of a number of policy options to strengthen the primary care system would likely improve health system performance.[28] However, a distinction must be made between simply providing patients with access to the existing primary care system versus making structural changes in the delivery system to achieve the level of service called for by most definitions of medical home. While there have been few large-scale demonstrations of medical homes, there is growing evidence that demonstrates the benefits of the core features of the Patient Centered Medical Home model in achieving better health outcomes, higher patient satisfaction, and lower overall costs.

Continuity of Care – A comprehensive review of studies evaluating continuity of care found that continuity of care, usually measured as seeing the same provider over time, is consistently associated with a number of positive effects including improved delivery of preventive services, decreased emergency room utilization, decreased hospitalization

[21] Shi L. Primary Care, Specialty Care and Life Chances. International Journal of Health Services. 1994:24:431-458.
[22] Shi L, Macinko J, Starfield B, et al. Primary Care, Social Inequalities and All-Cause, Heart Disease and Cancer Mortality in US Counties, 1990. American Journal of Public Health. 2005;95:674-680.
[23] Baicker K, Chandra A. Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care. Health Affairs. Web Exclusive. 2004.
[24] Macinko J, Starfield B, Shi L. The Contribution of Primary Care Systems to Health Outcomes Within Organization for Economic Cooperation and Development (OECD) Countries, 1970-1988. Health Services Research. 2003;38:831-865.
[25] Backus L, Moron M, Bacchetti P, et al. Effect of Managed Care on Preventable Hospitalization Rates in California. Medical Care. 2002;20:315-324.
[26] Bodenheimer T, Fernandez A. High and Rising Health Care Costs. Part 4: Can Costs be Controlled While Preserving Quality? Annals of Internal Medicine. 2005;143:26-31.
[27] Franks P, Fiscella K. Primary Care Physicians and Physician Specialists as Personal Physicians. Health Care Expenditures and Mortality Experience. *Journal of Family Practice.* 1998;47:105-109.
[28] Starfield B, Shi L, Macinko J. Contribution of Primary Care to Health Systems and Health. Milbank Quarterly. 2005;83(3):457-502.

rates, and increased patient satisfaction.[29] In addition, strong, continuous physician-patient relationships have been associated with lower costs of care.[30]

Team-Based Approach to Care **–** A significant body of literature supports both short-term and long-term benefits of care delivered by a multidisciplinary team, especially for patients with chronic disease. For instance, studies of patients with diabetes have reported higher patient satisfaction, improved quality of life, better health outcomes, and decreased cost of care when patients are treated by a team, rather than by a single physician.[31]

Coordination of Care – A wealth of evidence exists to show that care management programs and other strategies to coordinate the care of patients with complex medical conditions can improve quality and reduce costs. This type of care management has been widely embraced across the country. However, the disease-specific approach is impractical in patients with multiple chronic conditions. Further, carved-out disease management programs duplicate services that could be delivered by a single, trusted medical home. A variety of studies have shown that various care coordination strategies (e.g. health care teams including full time RNs or care managers dedicated to care coordination) can improve care in certain populations of complex patients, such as children with special health care needs.[32] The goal of a medical home model is to provide person-based coordination of an individual's health care needs at the level of their primary provider, rather than coordination based on a specific disease or condition.

Health Information Systems – Health information systems such as electronic medical records will form the basis of many quality improvement efforts, including efforts to manage the health of populations at the primary care level. In addition, such systems will become essential as primary care providers are asked to generate practice and individual-level data under pay-for-performance financing models. Early studies of the implementation of electronic medical records have shown that such systems can reduce primary care practice costs and provide data that improves the quality of care.[33,34]

Improved Access **-** A recent national survey found that patients who are seen by a provider meeting four indicators of improved access to care (regular source of care, easy phone access, weekend/evening access and efficient, on-time visits) received better care

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[29] Saultz JW, Lochner J. Interpersonal Continuity of Care and Care Outcomes: A Critical Review. Annals of Family Medicine. 2005;3:159-166.

[30] Robert Graham Center, The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change, November 2007.

[31] National Diabetes Education Program. Team Care: Comprehensive Lifetime Management of Diabetes. Available: http://ndep.nih.gov/diabetes/pubs/TeamCare.pdf

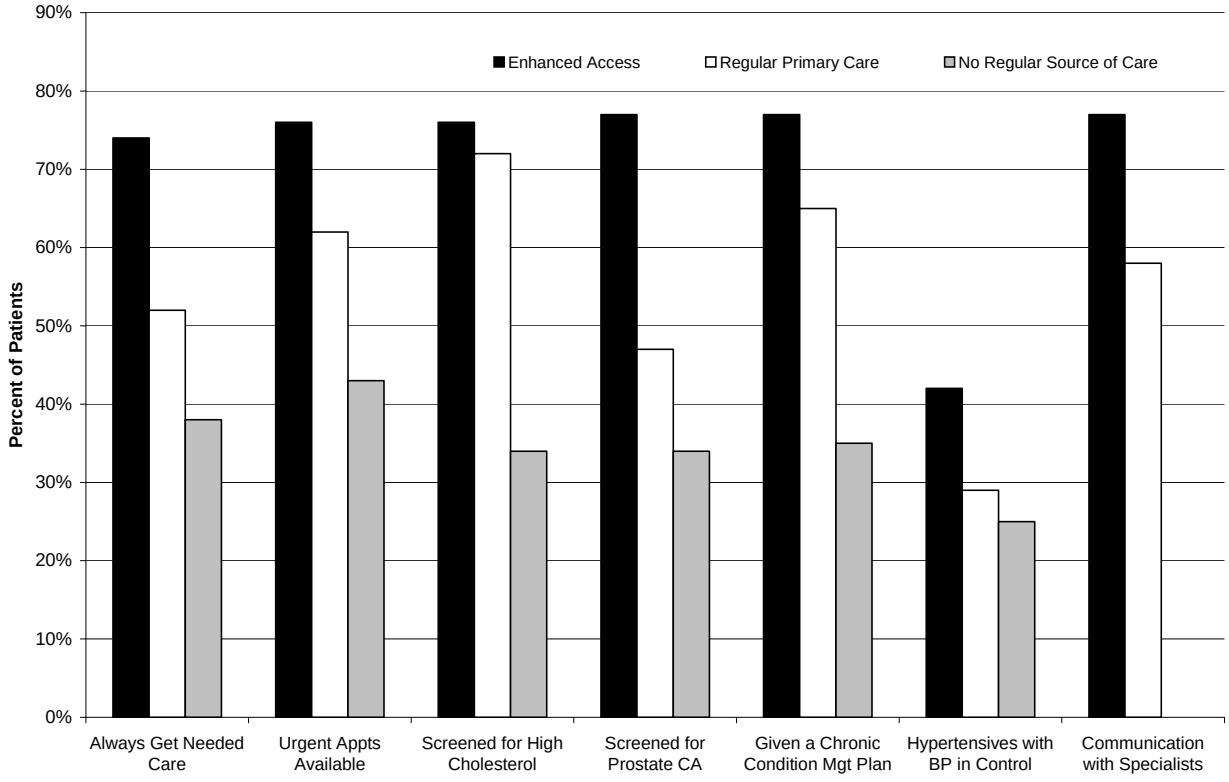
[32] Wise PH, Huffman LC, Brat G. A Critical Analysis of Care Coordination Strategies for Children With Special Health Care Needs. Technical Review No. 14. AHRQ Publication No. 07-0054. Rockville, MD: Agency for Healthcare Research and Quality. June 2007.

[33] Miller RH, West C, Brown TM, et al. The Value of Electronic Health Records in Solo or Small Group Practices. Health Affairs. 2005;24(5):1127-1137.

[34] Jamtvedt G, Young JM, Kristoffersen DT, et al. Audit and Feedback: Effects on Professional Practice and Health Care Outcomes. Cochrane Database of Systematic Reviews. 2006 (2): CD000259.

than patients seen by other providers (Figure 2).[19] Limited access to care is a key driver of socioeconomic health care disparities, and improving access reduces or eliminates health disparities by race and insurance status across the seven measures shown in Figure 2.[35] There is evidence that a variety of strategies to improve access (e.g., group visits, communication by phone and e-mail, after-hours accessibility) may improve the efficiency, equity, and efficacy of primary care.[36]

Figure 2: Effect of Enhanced Access to Care



Source: Beal, et al., Commonweath Fund, June 2007.

Overall Demonstrations of the Medical Home Model – While medical homes have not been implemented in the U.S. on a large scale, a number of local demonstration projects have shown that the medical home model can produce tangible results.

The Southcentral Foundation in Alaska (see ***Medical Home Initiatives***) lead an implementation of a medical home model at the Alaska Native Medical Center which improved a variety of care measures over a 5-year period, including decreased overall

[35] Andrulis DP. Access to Care is the Centerpiece in the Elimination of Socioeconomic Disparities in Health. Annals of Internal Medicine. 1998;129(5):412-416.
[36] Bodenheimer T, Grumbach K. Improving Primary Care: Strategies and Tools for a Better Practice. Chapter 7: Alternatives to the 15-minute Visit. McGraw-Hill Companies, Inc. 2007.

and disease-specific hospitalizations, improved childhood immunization rates, decreased emergency room and provider visits, and decreased visits to specialists.[37]

Implementation of a care-management based medical home model at Intermountain Health Care in Salt Lake City resulted in significant health improvements, including improved glycemic control, decreased hospitalization rates and decreased death rates in elderly patients with diabetes, compared to patients at control clinics.[38]

The available evidence does not support the conclusion that there is one "right" model of primary care delivery. It does, however, show that redistribution of limited health care resources with investment to the medical home bundle of services can be an effective strategy for improving individual health, population health, and overall health system performance.

As the Oregon Health Fund Board works to integrate the medical home concept into the Oregon Health Fund Program, it will be important to consider the special needs of communities across the state. There may not be one model that works for everyone and the services provided by a medical home and the manner in which care is delivered will likely have to vary to meet the needs of specific populations, especially those considered to be vulnerable due to socioeconomic status, race or ethnicity, geographic location or chronic disease conditions. The resources dedicated to expanding primary care through the utilization of medical homes must be directed to help communities fulfill these individual needs while maximizing community health.

Provider Incentives and Financial Models

A critical barrier to the implementation of the medical home model is the current payment structure which supports only face-to-face office visits and limited reimbursement for case management services provided by nurses and other members of a care team.[39] Without changes in policy, primary care providers have little incentive to expand their activities to include optimal primary care functions such as care coordination or expanded access via extended hours, e-mail, or phone communication. In addition, physicians are not rewarded for reduced spending achieved through better disease management or for improving quality of care. Furthermore, there are few or no incentives to invest in electronic medical records, data collection systems, or other infrastructure changes to improve the quality and safety of care.

Researchers, professional societies and others have proposed a variety of mechanisms to finance a re-designed primary care system. While there is no clear consensus or evidence

[37] Eby D. Healthcare Transformation. Presentation at the Oregon Community Health meeting. Southcentral Foundation Alaska Native Medical Center. December 2006

[38] McConnell J, Dorr D, Radican K, et al. Creating a Medical Home Through Care Management Plus. Presentation at Academy Health Annual Meeting. April 10, 2007.

[39] American Academy of Pediatrics. The Medical Home: Policy Statement. Pediatrics. July 2002; 110(1): 184-186.

to support a single, best financing mechanism, there is general agreement on a number of key attributes, including the following:

- Payment reform is critical component of any effort to re-design primary care and promote the medical home model.
- Funding mechanisms must be transparent to providers, plans, and consumers.
- Funding mechanisms must provide reimbursement for services and activities not currently covered under traditional fee-for-service (FFS) payments. These include coordination of care, improved access, and care management.
- Funding mechanism must reward providers for improving health outcomes, improving quality of care, and decreasing cost through better preventative and disease management services.
- Payers must recognize that there are transitional and start-up costs associated with moving to a medical home model, including investments in health information technologies.
- Regardless of the payment mechanism, resources will need to be redirected to optimize the level of primary care service.

Medical homes have been implemented under a diverse range of financing structures from capitated managed care plans to staff model HMOs to traditional multi-payer FFS systems with bonuses and carved out payments for specific services. Below is a summary of a number of payment models that could be employed by health plans to support medical homes. A table comparing these models is shown in Appendix B.

Pay for performance – Pay-for-performance programs provide enhanced FFS rates and/or bonus payments to providers based on the achievement of specific clinical outcomes or benchmarks. *Example incentive*: Annual bonus payment to providers for meeting a clinical outcome goal, such as a target immunization rate or percent of diabetics in good glycemic control.

Pay for process – Pay-for–process programs are similar to pay-for-performance ones, but they include bonuses for meeting process benchmarks and indicators, rather than specific clinical outcomes. *Example incentive*: Annual bonus payment to providers for meeting a process goal, such as implementation of an electronic medical record (EMR) or maintaining a diabetic registry.

Comprehensive prospective payments – Prospective payments could be given on a per-client basis, risk-adjusted for patient mix, to cover the full range of medical home services. Payments could include disbursement guidelines to require a certain practice structure, staffing level or other practice characteristic (e.g. EMR for every patient) to receive the full payment. Unlike traditional capitated payments, prospective payment would not require providers to assume financial risk for non-primary care costs such as specialty and hospital care. *Example incentive*: Annual payment of $500 per enrolled patient for providing a predetermined package of primary care services, with guidelines as to the appropriate level of service.

FFS reimbursement for non-reimbursed activities – Billing codes could be created for activities other than face-to-face office visits, such as case management, telephone and e-mail encounters, and group visits, to allow physicians and other providers to bill for these services. *Example incentive*: Case management reimbursement codes with assigned relative value units (used to track physician productivity and performance) could generate revenue for primary care practices, allowing them to bill for services consistent with the medical home model.

One-time start-up grants/demonstrations and technical assistance – One-time payments and educational services could be provided by payers to assist providers, especially those in small or solo practices, with systems change. *Example incentives*: $5,000 one-time grant payment to a small practice to support the implementation of an EMR, educational course for providers on staffing models for a medical home practice, or training course for primary care case managers.

Carved out case management and disease management services – Health plan could sponsor case managers/disease managers assigned to specific providers and/or regions. Unlike traditional disease management, case managers hired by a health plan would work closely with primary care providers through a shared medical record and frequent communication. Physicians could refer complex patients to the case manager for additional support and patient education. Shared information systems would allow the physicians to manage overall care and work collaboratively with case managers. *Example incentive*: Physician refers a complex patient to a case manager, who develops an ongoing management plan and educational interventions and shares plans with the physician. Utilization of case management could improve practice efficiency through the off-loading of work, which would motivate physicians to utilize case management.

Mixed models – A number of organizations have proposed mixed financing models that retain FFS payments for in-person visits but add various prospective and bonus payments to support medical home services.[40,41,42] The most common additions in mixed financing models include:

- Prospective payments to cover a bundle of specific services consistent with the medical home model. *Example incentive*: $100-200 annual payment per patient for practices accredited as medical homes.
- Prospective payments to cover specific overhead costs or practice improvements. *Example incentive*: $10 annual payment per patient for practices with an EHR.
- Incentive/bonus payments for quality improvement. *Example incentive*: $80 annual bonus per patient for meeting quality benchmarks for diabetic care, $5 annual bonus per patient for establishing patient education programs.

[40] Kirschner N, Doherty R. A system in need of change; restructiring payment policies to support patient-centered care. American College of Physicians. October 2006.
[41] Spann SJ. Task Force Report 6. Report on financing the new model of family medicine. Annals of family medicine. 2004;2 supp 3:S1-S21.
[42] Bridges to Excellence Project. www.bridgestoexcellence.org

- Direct FFS reimbursement for currently non-reimbursed activities such as e-visits, telephone visits, etc.

The Patient-Centered Primary Care Collaborative developed a mixed payment model, which the group believes could realign incentives to support the primary care medical home. The model maintains traditional FFS for face-to-face office visits combined with a monthly risk-adjusted prospective "care coordination payment" to cover the cost of services outside of the face-to-face visit and necessary investment in health information technology. The collaborative model also includes a performance payment that rewards medical homes that are able to delivery high quality and cost-effective care.[43]

At this time, there is no strong evidence to support a single, best financing model, although mixed models appear to be the most common in practice. This is likely because it is easier to build on top of current FFS reimbursement than to develop entirely new systems. Financing models employed successfully in Oregon and elsewhere are discussed below in ***Medical Home Initiatives.***

Barriers to Delivery System Change in Primary Care

There are a number of key systems and cultural and policy barriers that must be addressed in any effort to move towards a medical home model of primary care. It will be necessary for the Oregon Health Fund Board to address these challenges if primary care revitalization is going to be incorporated into statewide delivery reform, but it is not necessary to completely reinvent the wheel. There are a number of organizations and programs in the state and across the nation that have started to address these issues and develop innovative solutions from which important lessons can be drawn. Demonstration projects and other efforts to transform primary care practices into medical homes have been initiated by many different stakeholders in the health care industry – public and private purchasers, private insurance carriers and public insurance programs, individual health systems and clinics, professional organizations, and non-profit organizations have all been involved.

Some of the barriers to delivery system change are explored below, along with a description of some efforts to overcome these obstacles. More comprehensive efforts to implement the patient-centered medical home model in real world settings are discussed below in ***Medical Home Initiatives.***

Inadequate funding – One major barrier to establishing medical homes is inadequate funding for primary care, especially in the areas of preventative care, disease management and care coordination services. In demonstration projects where implementation of a medical home model has produced positive results, additional resources have been directed towards the primary care system. These resources are typically used to improve infrastructure, hire support staff, and allow providers to deliver

[43] Patient Centered Primary Care Collaborative. A New Physician payment System to Support Higher Quality, Lower Cost Care Through a Patient-Centered Medical Home. May 2007. Available: http://www.pcpcc.net/node/9

care outside of face-to-face visits. While multiple different funding mechanisms have been successfully employed, it is clear that quality and efficiency improvements in primary care will require a redistribution of financial resources.

Absence of common vision among primary care providers – While many leaders in primary care have embraced the concepts of the medical home model, it is not clear that a majority of practicing clinicians share this vision. In a 2006 physician survey, one-third of primary care providers felt that team-based care was cumbersome, and 21% felt it would increase medical errors.[44] Only 23% of primary care providers reported currently using an electronic medical record, and only 23% plan to implement an EMR in the near future. Less than half of respondents send their patients reminder notices for regular follow-up or preventive care. Fortunately, new efforts to build support for primary care reform among health care providers in Oregon could add needed grass-roots support for system reforms. Projects such as the Archimedes Movement, the Better Health Initiative, and the Oregon Health Reform Collaborative are working to build a unified vision of delivery system reform within the health care community.[45,46]

The medical home concept is also a significant part of the national dialogue on health reform and quality improvement. As discussed above, the Patient-Centered Primary Care Collaborative unites the major primary care physician associations, which together represent 330,000 primary care physicians, and major national employers, health benefits companies, trade association, academic centers and quality improvement associations around the medical home concept. The Collaborative supports a single set of core features of the medical home and works to promote and advance the patient-centered medical home on a national scale. The coalition held a national "Call-to-Action" summit focused on the medical home in Washington, DC in November 2007.[47]

Dilution of financial incentives – A large number of payers are involved in the financing of health care. In order for quality improvement incentives to be effective, they must be large enough to encourage primary care providers to change the way they practice. In a multi-payer market, if only a few payers provide modest financial incentives, incentives will be ineffective in creating change. The same will be true if many payers encourage different behaviors or outcomes. Organizations such as PEBB and the Oregon Health Care Purchasers Coalition are working to address this problem by trying to align payers around common quality improvement incentives in both the public and private sectors. Other states such as Minnesota have taken a similar approach, trying to align the incentives used by all public purchasers of health care.

Premature expectations of progress – Many proponents of primary care and the medical home model advise caution in expecting rapid progress. Experience shows that

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[44] Audet A, Davis, K and Schoenbaum SC, Adoption of Patient-Centered Care Practices by Physicians. Archives of Internal Medicine. 2006. 166(7):754-759.
[45] Oregon Health Reform Collaborative. http://www.oregonhealthreform.org/
[46] Archimedes Movement. http://www.archimedesmovement.org
[47] Patient-Centered Primary Care Collaborative. http://www.patientcenteredprimarycare.org/index.htm

investments in primary care systems can produce tangible results; however, they should be viewed as long-term investments, not short-term solutions to prevent budget problems in the next legislative cycle. While some demonstration projects have received results in a short time frame, this experience is not likely to be generalizable when a medical home model is implemented more widely. Efforts that focus on improving quality of care for one condition may see quicker results. However, the medical home concept requires system change that addresses all of a patient's needs, and this type of change does not occur quickly. Once a program is implemented, it can take years for system changes to become widespread and additional years to see cost and quality improvements. This is especially true in the management of chronic disease, where improvements in care are likely to prevent costly complications years or decades in the future. Likewise, the return on investment from preventative care may not be realized until significant time has lapsed.

Habituation to misaligned or absent incentives – The current health care system is not structured to advance the goals of improved quality, decreased cost, and enhanced efficiency. Providers are rewarded for increasing volume, while health plans control their costs by limiting and reducing benefits. Other than the beneficent desire of providers and plans to provide good care to patients and clients, there are few formal incentives to improve the quality of care, to coordinate care, or to make care more accessible. Everyone involved with health care has become accustomed to doing business under the current system with its absent and misaligned incentives. While "aligning incentives" seems an obvious solution, significant leadership and education will be needed to help habituated providers and administrators understand and embrace the vision of a health system centered on medical homes.

Lack of readiness for change – Nearly all of the research and demonstration projects surrounding medical home have been conducted in controlled environments where motivated and willing individuals became educated about health system re-design and created change, often after applying for grant funding to do so. Implementing widespread change of the primary care system will require change by those who have not been educated about system re-design and may not be motivated to change. Changing the way care is delivered and financed requires different skills than those needed to continue operating in the current system. Even with sufficient financial resources, those accustomed to the current system may need education, technical assistance and support to foster change. One model for providing such support at the health plan level is the PEBB "Council of Innovators" (see ***Medical Home Initiative***). At the practice level, CareOregon is developing expertise in supporting primary care re-design and professional societies such as the American Academy of Family Physicians have resources to help guide primary care practices through the re-design process.

An open system – The American health care system is often called an "open system." There are few restrictions on how patients access the health care system. For a medical home model to be most effective, the medical home should be the point of first contact for all non-emergent medical services. In communities where there is only one medical provider or a single hospital or health system, the open system problem is less severe. However, in urban areas with many specialists and hospitals, care can easily become

fragmented and disorganized. Patient education and frequent contact with clinic staff can help combat the open system problem, as can health plan efforts to link patients with a primary care provider and encourage a single access point through the medical home.

Medical Home Initiatives and Demonstration Projects in Oregon and Elsewhere

(This section does not provide an exhaustive list of innovations and initiatives, but seeks to describe examples of efforts initiated by a variety of stakeholder groups)

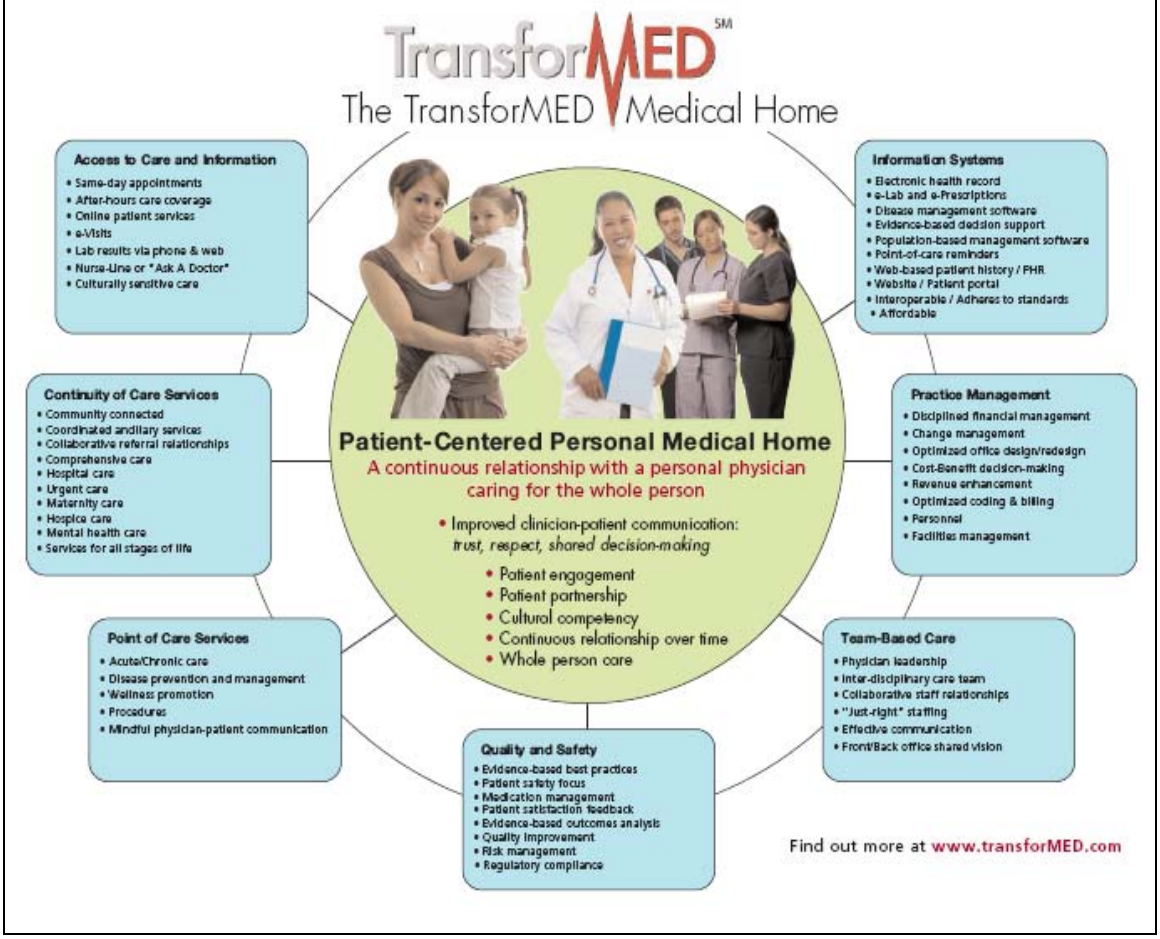
National Organizations

National Committee for Quality Assurance – Before practitioners can be rewarded for providing medical home services to their patients, it is necessary to develop standards and metrics by which the characteristics of a medical home can be measured. The National Committee for Quality Assurance (NCQA) developed the Physician Practice Connection (PCC) tool to recognize practices that "use information to improve the quality of care delivered to patients". The tool evaluates a practice's ability to use systems to track patients' treatments and conditions; manage patient care over time; support patient self-management; utilize electronic prescribing; track and follow up on lab results, imaging tests, and referrals; measure performance and efforts to improve performance; and move towards interoperable information systems. Recently, the NCQA updated the PCC so that it can be used to measure the degree to which a practice exemplifies "patient-centered primary homeness." New measures capture patient communication by telephone and email, in addition to in-person visits, expanded access, care management, availability of culturally and linguistically appropriate services, and the overall patient experience. The tool can now be used to qualify and recognize primary care medical homes and measure the degree to which the characteristics of a medical home are associated with higher quality care.[48]

TransforMED – In 2006, TransforMED, an affiliate of the AAFP, launched a 24-month national demonstration project. Thirty-six sites were selected across rural, suburban, and urban settings to redesign their practices based on the TransforMED Medical Home Model (Figure 3). Central Oregon Family Medicine, PC, a medium size practice (4-6 physicians) in Redmond, OR was one of the practices selected. Eighteen of the practices are undergoing self-directed reform, whereas the other 18 are participating in a facilitated process that includes frequent site visits, message boards, blogs, conference calls, electronic seminars, and collaborative meetings. Real-time evaluation of all sites is being lead by The Center for Research in Family Medicine and Primary Care and is looking at patient satisfaction, physician and staff satisfaction and quality of life, clinical process and outcome measures, and financial impact on practice revenues and physician income. Lessons and best practices will be published in peer-reviewed journals so that other practices can learn from the demonstration project.[49]

[48] Pawlson G. Executive Vice President, National Committee for Quality Assurance. Assessing the Patient-Centered Medical Home. Presentation at Patient-Centered Primary Care Collaborative Call-to-Action Summit. Washington, DC. November 7, 2007.
[49] TransforMED. http://www.transformed.com

Figure 3: TransforMed Medical Home Model



State Level

Q-Care in Minnesota - In 2006, Minnesota's governor signed an executive order to increase the impact of value-based purchasing efforts in the state. The executive order requires all state purchasers of health care to include a common set of "Q-Care" quality standards in their contracts with health plans and providers. Purchasers must also implement financial incentives (pay-for-performance) to achieve specific quality improvement targets. The initial Q-Care effort focuses on quality improvement in four areas: diabetes care, cardiovascular care, hospital care, and preventive care. At the primary care level, incentives will encourage the attainment of specific clinical targets, such as glycemic and cholesterol control for patients with diabetes, blood pressure control for cardiovascular patients, and rates of immunizations and disease screening in eligible populations. To encourage the use of Q-Care standards more widely, the state is partnering with private purchasers and local governments. The effort is being coordinated through the Governor's "Health Cabinet" and the State Center for Health Care Purchasing Improvement, which was established in 2006.[50] While these efforts in Minnesota are not specifically looking to establish a medical home model of care, payments based on quality improvement could provide additional revenue needed to support changes in the primary care system.

[50] QCare. http://www.health.state.mn.us/healthinfo/qcare.html

Community Care of North Carolina – The North Carolina Department of Health and Human Services has built community health networks to deliver primary care to the state's Medicaid population. There are currently fourteen networks in the state, which include physicians, hospitals, pharmacists, local health departments, social service agencies, and other safety net and community-based providers. The state pays networks a per-member/per-month (PMPM) fee to manage care for a group of enrollees and hire case managers and medical management staff to support primary care physicians in the networks. The networks create the infrastructure to allow small practices to share case managers, while larger provider groups may be assigned their own support staff.[51] Primary care physicians in the networks are paid an additional PMPM payment to provide medical home services, including quality improvement and disease management efforts.[52] Each network has established medical and administrative committees that are tasked with developing tools to help providers in the network implement disease management services, manage high-risk patients and high-cost services, and build accountability among providers. Leading physicians from each network work together to establish clinical guidelines and best practices in different care areas and have established initiatives in the areas of asthma disease management, congestive heart failure disease management, diabetes disease management, emergency room, pharmacy management, and case management of high-risk and high-cost patients. These initiatives have resulted in significant cost savings for the state Medicaid program and improved health outcomes.[48]

Purchaser Level

Public Employees' Benefit Board (PEBB) – PEBB designs, purchases, and administers health care and other benefits for state employees and their dependents. PEBB is the largest employer-based purchaser in the state of Oregon, covering 120,000 lives. In 2004, PEBB decided to use its purchasing power to encourage delivery system reforms that improve the quality and affordability of health care. They developed a 2007 Vision for a "new state of health", which included the following principles: provision of evidence-based medicine; a focus on improving quality and outcomes; promotion of consumer education, healthy behaviors, and informed choice; alignment of market incentives; transparency at all levels of the system; and affordability. PEBB used these guiding principles to develop a value-based purchasing initiative and issued a request for proposals (RFP) for vendors interested in providing health benefits under this new plan.

Applicants were scored on technical criteria across seven dimensions that PEBB decided were closely aligned with the plan's ability to provide high-quality and high-value care to its enrollees. Heavy weight was given to vendors' ability to meet quality criteria in the domains of medical home (25% of score) and evidence-based care (20% of total score). Examples of technical criteria in the primary care area included systems measures

[51] North Carolina Community Care. North Carolina Community Care Fact Sheet. October 2007. Available: http://www.communitycarenc.com/WordDocs/CCNC%20AT%20A%20GLANCE.doc

[52] Dobson LA. Former Assistant Secretary, North Carolina Department of Health and Human Services. Improving Medicaid Quality and Controlling Costs by Building Community Networks of Care. Presentation at Patient-Centered Primary Care Collaborative Call-to-Action Summit. Washington, DC. November 7, 2007.

(percent of primary care providers with an EMR), process measures (patient satisfaction surveys and care management programs) and financial/outcome measures (implementation of pay-for-performance and other incentive structures). The other dimensions used to score vendor applications included evidence-based care, member self-management, service integration, infrastructure, transparency, and managing for quality.[53]

PEBB received nineteen responses to their RFP and ultimately selected four vendors to provide health benefits: Kaiser Permanente, Regence BCBS, Providence Health, and Samaritan Health. Contract renewal will be contingent on the plans' ability to demonstrate improved performance and at least incremental change in reaching the high rating criteria established in the RFP. In order to achieve a high rating on the medical home dimension, plans will have to be able to document that all enrollees are offered a medical home, require providers to report on preventative and screening services, measure outcomes for enrollees with certain target conditions, and demonstrate that a large percent of their primary care physicians have access to EMRs. In addition, the vendors agreed to participate alongside PEBB representatives on a "Council of Innovators" to focus on continued quality improvement and review and make recommendations regarding implementation of the 2007 Vision.[54] The Council provides a unique opportunity for public and private representatives to work together to explore options for encouraging primary care revitalization centered around the medical home model, as well as larger delivery and quality improvement reforms.

Oregon Health Care Purchasers Coalition (OHCPC) – The OHCPC is a non-profit organization of public and private purchasers of health care (including PEBB), working to improve purchasers' ability to buy high-value health care for their employees. The OHCPC seeks to use the joint purchasing power of the public and private membership to change the way health is delivered and improve health outcomes across the state. In 2007, the OHCPC started to use eValue8, an evidence-based survey tool which collects and compiles information from health plans on hundreds of process and outcome measures. Eight Oregon plans agreed to submit data to eValue8, and data was collected and evaluated in the areas of plan profile, consumer engagement, provider measurement, prevention and health promotion, pharmaceutical management, chronic disease management, and behavioral health. While the tool does not specifically measure a plan's ability to offer its enrollees a medical home, many of the desired characteristics of a medical home are captured in the other dimensions. In this first year, results were used for quality improvement efforts – plans were able to compare their own performance with other plans in the state and nation and the OHCPC members were given the opportunity to meet and discuss results with each participating plan. In the future, OHCPC will seek opportunities to increase the number of plans that participate in the survey and release

[53] PEBB Vision for 2007. http://pebb.das.state.or.us/DAS/PEBB/vision.shtml
[54] Aron Consulting. PEBB Guiding Principles and RFP Preferences. November 16, 2004. Available:http://egov.oregon.gov/DAS/PEBB/docs/Word/2PEBBVisionRFPGuidingPrinciplesRevised111204.doc

results to a wider audience.[55] By providing a standard set of measures by which quality and performance can be evaluated and plan performance can be differentiated, eValue8 can help purchasers make value-based purchasing decisions. The eValue8 process also helps plans to realize the importance of consumer engagement and health promotion strategies identify areas for improvement.

Plan/Health System Level

Southcentral Foundation "Alaska Model" – The Alaska Native Medical Center (ANMC), owned and managed by the Southcentral Foundation, is a group medical practice and tertiary referral hospital in Anchorage, Alaska. The center serves Alaska natives in a large area of southwest Alaska. The medical center is supported by funds from the Indian Health Service, as well as payments from insured patients through Medicaid, Medicare, and private insurers. The primary care system of the ANMC has served as a model and illustration of ways in which the medical home can be used to improve health care. The model is built on the values of the community it serves, which include a holistic approach to health and the importance of strong relationships between providers and patients. Small primary care teams are formed around the patient, which include the patient's family and primary care provider, as well as support from a medical assistant, nurse, and behavioral health specialist. Consultations with specialists frequently occur as brief phone conversations. Providers and others on the patient care team also provide a number of visits and checkups over the phone in addition to in-person visits. The increased efficiency and quality improvements achieved at ANMC are discussed above.

Regence Blue Cross Blue Shield – Regence is a not-for-profit insurer providing coverage for Oregonians across the state. As a traditional insurance company operating primarily as a preferred provider organization, Regence has two major lines of business: traditional insured clients and administrative only clients who are self-insured by large employers. Regence has four pilots underway that are helping providers build provider capacity to provide medical home services to their enrollees. The first is the Clinical Performance Improvement Pilot Program, which was designed to create partnerships with physician groups to improve quality of care. Regence provided grants to seven practices in 2006 and five practices in 2007 and criteria for selection included the intention to implement the patient-centered chronic care model. Most of the projects have focused on improving quality of care for patients with diabetes. In addition, Regence has worked with physicians at Oregon Health and Science University (OHSU) to evaluate a reimbursement system tied to quality improvement of patients with diabetes. In the model, reimbursement is provided for group visits, remote care and team case management. Regence has also worked with a number of primary care practices to use patient-satisfaction surveys to direct patient improvement plans and to build provider capacity using health information technology. Regence is currently planning a more comprehensive pilot to develop Primary Care Home Collaboratives in Oregon and Washington.

[55] Thorne J. Administrator, Public Employees' Benefit Board. Value-Based Health Care Purchasing. Presentation at Oregon Health Fund Board Delivery System Committee. November 15, 2007. Wilsonville, OR.

At the national level, the Blue Cross Blue Shield (BCBS) Association and more than twenty BCBS companies, including Regence in Oregon, recently announced a partnership with the Patient-Centered Primary Care Collaborative to develop a medical home demonstration project. The Patient-Centered Primary Care Collaborative will be sponsoring the companies' design of alternative models of patient-centered medical homes. The companies will also explore options for aligning provider incentives with the goals of a medical home and integrating quality improvement and care management into the primary care home model. Patients will be educated about the benefits of a medical home and be given the opportunity to receive care through a medical home site.[56]

Samaritan Health System – Samaritan is a not-for-profit health system covering three counties in southeast Oregon. Samaritan owns five hospitals and has over 200 employed physicians. The health system has a strong sense of community mission and community involvement. It also operates four insurance products: a Medicaid managed care plan, a Medicare managed care plan, self-insurance for its employees, and a contract with PEBB for state employees. Samaritan has just completed the implementation of an EMR and is actively considering how to develop measurement systems and payment incentives to support quality improvement in primary care. One step the plan has adopted is uniform productivity-based payment for its providers, regardless of patient insurance status. There have been no formal efforts to re-design primary care practices in a medical home model, though Samaritan is considering how to implement performance improvement measures under its contract with PEBB.

CareOregon– CareOregon is the largest Medicaid managed care plan in Oregon. It is currently operating a medical home demonstration called the Primary Care Renewal Project at five safety-net clinics in the Portland area. The demonstration is providing grant support and technical assistance to these clinics, with the goal of re-designing primary care practice using Southcentral Foundation model (see above). The focus of the demonstration project includes restructuring primary care teams to provide increased support and patient management from nurses, medical assistants, and on-site behavioral health experts. Technical assistance focuses on quality improvement and performance measures at each practice. If the project is successful in the first year, CareOregon may investigate alternative reimbursement mechanisms to continue supporting these re-designed practices.

The five safety-net demonstration clinics participating in the CareOregon Primary Care Renewal Project are Legacy Emmanuel Internal Medicine, Oregon Health Sciences OHSU Richmond Family Health Center, Old Town Clinic, Multnomah County Mid-County Health Center, and Virginia Garcia. While each of the clinics is taking a different approach to the project, common features include empanelment of patients with small primary care teams, implementing team-based care with increased support from RNs, case managers and medical assistants, "scrubbing" charts before visits to identify care needs, "max-packing" visits to deliver all needed services (including prevention) at each

[56] BCBSA Demonstration Project Press Release. November 7, 2007. Available: http://www.pcpcc.net/node/50

visit, and outreach to patients in need of disease management or preventive services. There is a strong focus on quality improvement and performance improvement at each site, as well as an effort to move towards population-based care management.

Kaiser Permanente – Kaiser Permanente is the largest non-profit health plan in the country and serves its enrollees with an integrated health delivery system designed to provide and coordinate care across all of patients' health needs. All Kaiser members select a single primary care provider to serve as their personal physician and enrollees are encouraged to access their physicians through phone and email encounters, as well as office visits. In addition, every Kaiser patient has an electronic medial record and all care provided by any Kaiser provider is documented within the system. Members can access some of the information in their medical record, including appointments, medical conditions, lab results and vaccination records, through the Kaiser website.

Provider/Clinic Level

OHSU Care Management Plus Project – The Care Management Plus Project is a medical home demonstration project operated by a research team at OHSU. The team piloted this primary care model at Intermountain Health in Utah and is now developing similar programs in the General Internal Medicine practice at OHSU and in other practices around the state; currently, over 40 clinics have adopted or are adopting the program. The Care Management Plus model enhances the primary care team by designating care managers as a primary contact in the medical home for patients with complex needs and older adults. The program (development and dissemination funded by The John A. Hartford Foundation) trains care managers to help patients set goals, achieve lifestyle changes, and follow individualized treatment programs. Information technology use is assessed and recommendations are made to enhance use of IT to better meet the longitudinal needs of patients; a freely available tool is provided on the website. Care managers go through a specific training, which has been developed by the Care Management Plus Project. While grant support is used to train care managers, manager salaries are supported by their associated clinic. Care managers work with several (5-10) providers on a referral basis to coordinate the care of complex patients and assist with patient self-management. Data from Care Management Plus at Intermountain Health in Utah is discussed above.[57] The program has compared its additional functionality with the NCQA Physician Practice Connection tool, and found that the differential approach of a care manager can help meet a number of the specifications of the tool. The research team also has informaticians who map the expected functionalities of electronic health records from the Certification Commission for Health Information Technology to better support the specific longitudinal needs of patients with complex illnesses.

GreenField Health – GreenField Health is a redesigned medical practice in Portland. GreenField focuses on expanded access to care through e-mail and phone consultations with providers, same day appointments and improved work flow and practice design. GreenField supports its activities through traditional FFS insurance payments and an annual patient fee that provides about 50% of practice revenues. This fee supports

[57] OHSU Care Management Plus. www.caremanagementplus.org

clinician time to provide services that are not covered by insurance. It also supports a panel size of about 1,000 patients per full time provider. In addition to providing primary care, GreenField runs a consulting business to help other practices and medical systems with practice management and primary care redesign.

Oregon Primary Care Association (OPCA) – The Oregon Primary Care Association is working to build a more robust primary care model in community health centers in Oregon that meets the various needs of vulnerable populations. As part of these efforts, OPCA provides technical support and training to these clinics for implementing elements of the primary care home model and is working with the centers to measure the value of different elements of the model. Safety net clinics and community health centers may be uniquely positioned to provide patients with medical homes able to address health care and other social needs simultaneously. Many community health centers already offer enabling (non-medical) services, such as social case management, interpreter services, and transportation, tailored to meet the needs of the community they serve.

Key Considerations for the Oregon Health Fund Board

Below are eight steps for the Oregon Health Fund Board to consider that could encourage system change and build the state's capacity to provide all Oregonians with a primary care medical home.

#1 – ***Encourage and reward efforts to inform providers of the need for primary care reform and the characteristics of a patient-centered medical home.*** Support could build on efforts of ongoing initiatives such as the Better Health Initiative, Archimedes Movement, the Oregon Health Reform Collaborative, and the partnership between the Community Health Advocates of Oregon and the Oregon Primary Care Association.

#2 – ***Develop a standard definition of medical home and standard measures to determine whether primary care providers meet this definition. This definition should be broad enough to allow for innovation and encompass various models that provide medical home services to their patients.*** Current medical home definitions and metrics, such as the NCQA, PCC, or Medical Home Index developed for use in pediatric practices could serve as a starting point for this effort.[58]

#3 – ***Coordinate lessons from current demonstrations of medical home models in Oregon and encourage more demonstrations.*** Expansion and coordination of current demonstrations, as well as larger multi-payer local or regional demonstrations, could help build the knowledge and experiential base for the development of medical homes across Oregon.

[58] Cooley WC, McAllister JW, Sherrieb K, et al. The Medical Home Index: Development and Validation of a New Practice-level Measure of Implementation of the Medical Home Model. Ambulatory Pediatrics. 2003; 3:173-180.

#4 – ***Consider specific support for demonstration projects targeted at small practices and rural providers.*** There is little ongoing work to support the development of the medical home model in small practices and rural areas in Oregon, and these practices are likely to face unique challenges. Results of the AAFP TransforMED project may provide valuable data in this area.

#5 – *Consider specific support for demonstration projects targeted at high need or vulnerable populations.* Research has demonstrated that increased access to medical homes may decrease disparities in health outcomes, but the model will have to be tailored to meet individual and community needs. Such efforts could build on the current CareOregon demonstrations.

#6 – ***Develop a sustainable financing model that supports medical home services.*** Such a model could be based on the results of local demonstration projects or other national models.

#7 – ***Partner with other purchasers of health care to develop a uniform set of standards or common measures of clinical performance outcomes.*** This effort could build on the ongoing work of PEBB and the Oregon Health Care Purchaser's Coalition.

#8 – ***Consider how best to provide adequate funding for technical support, education and dissemination of best practices to support patient-centered primary care practice re-design.*** Primary care providers and health systems are likely to need specific assistance in multiple areas (e.g. practice redesign, staff training, and understanding new payment structures) as they work to implement the medical home model. This effort could build on current efforts such as the OHSU Care Management Plus, the CareOregon Primary Care Renewal Project, and the PEBB Council of Innovators.

Conclusion

Reforming the health care delivery system to revitalize primary care and promote the medical home model will require change at all levels of the system. Nevertheless, undertaking this change will likely provide significant improvements in the health of Oregonians, while also reducing the overall cost of health care delivery. Oregon has already begun implementing measures to reform its primary care system, and the OHFB can take advantage of these efforts as it works to develop a comprehensive reform plan for the state. Transforming the state's primary care practices into patient-centered primary care medical homes will be an important step in redesigning the health care delivery system to better serve the needs of people across the state. However, efforts in this realm will not be successful in isolation and must be seen as one part of a comprehensive effort to redesign the way health care is delivered and financed across the state.

Appendix A: Multiple Definitions of Medical Home

Joint Statement "Patient-Centered Medical Home" [16]	**AAFP "TransforMED model"** [59]	**ACP "Advanced Medical Home"** [17]	**AAP** ***"Medical Home"*** [15]	**OPCA "Primary Care Home"** [60]	**Commonwealth** ***"Medical Home"*** [19]
Personal physician	Personal Medical Home	Personal Physician	Long-term continuity	First point of access	Regular source of care
Physician-directed team practice	Team approach	Team Approach	Team-based care	Team-based care	
Whole person orientation – (comprehensive)	• Patient-centered care • Whole-person orientation • Consistent set of services	• Partnership with patients/families • Range of medical services	Comprehensive set of primary care services	Comprehensive and integrated care	• Patient-centered care
Integrated/Coordinated care across the health system, patient's community and culture	Integrated approach to care	Chronic Care model of care for all patients	• Coordination of subspecialty care and community resources • Cultural/developmental competence • Family-centered care	• Sustained patient/family-provider partnerships • Health system navigation and coordination • Cultural competence	
Improved access	• Elimination of access barriers • Re-designed offices	Improved access	24/7 Accessibility	Immediate access	• Evening/weekend access • Phone accessibility
Focus on Quality and Safety	• Focus on Quality and Safety • Data-based information systems • Electronic health record	• POC Evidence-based medicine and tools • Health information technology • Quality improvement programs	Confidential health record	Identifying and measuring process and outcomes measures	Efficient, well-organized, on-time visits
Payment that reflects value of services	Sustainable reimbursement	Revised reimbursement system		Working on multiple solutions	

[59] American Academy of Family Physicians. The New Model. TransforMed. www.transforMED.com. Accessed 7/3/07.
[60] Hostetler C. Testimony to the Oregon Senate Committee on Health Policy and Public Affairs. March 12, 2007

Appendix B: Comparison of Primary Care Financing Models*

	Pay for Performance	Pay for Process	Global Prospective Payments	FFS Payment for Non-Visit Services	One-Time Grants and Technical Assistance	Carved-Out Case Management	Mixed Models
Incentives and Impacts † [4]							
Includes Monthly per-patient payments	+/-	+/-	+	-			+
Includes Visit-based payments	+	+	-	+			+
Encourages providers to improve quality	+	+	+/-	-		+	+
Encourages providers to limit practice size	-	-	-	+		-	-
Encourages providers to care for complex patients	-	-	+	+		+	+/-
Encourages providers to re-design their practices	+/-	+	+/-	+	+		+/-
Supports adoption of infrastructure improvements (e.g. EHRs)	+	+	+	-	+		+
Increases requirements and responsibility of PCPs	+	+	+	-	-	-	+
Support of the Medical Home Principles ‡							
Personal Physician	-	-	+	-	-	-	+/-
Physician-directed Team Practice	+	+	++	++	-	+	+
Whole-person Orientation to Care	+/-	+	++	++	-	+/-	+
Care Coordination/Integration	-	++	+	+	+/-	+	+
Quality and Safety Improvement	++	+	+/-	-	+/-	+/-	+

* This table was compiled by the author based on reviewed literature and discussions with experts about the impact of various financing models.

† + Indicates that the financing model would encourage a certain provider/practice behavior, – indicates that the financing model would not encourage the behavior, and +/- indicates that the financing model may or may not do so, depending on specific policies adopted in designing the payment structure.

‡ + indicates that the financing model would support or strongly support (++) the development of a medical home characteristic in primary care practices, - indicates that the financing model would not have a strong impact on the development of a medical home characteristic, and +/- indicates that the model may or may not impact the development of a medical home characteristic, depending on specific policies adopted in designing the payment structure.

American Academy of Family Physicians (AAFP)

American Academy of Pediatrics (AAP)

American College of Physicians (ACP)

American Osteopathic Association (AOA)

February 2007

Introduction

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately

arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision making

- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication

1. Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
2. Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

1. It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
2. It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
3. It should support adoption and use of health information technology for quality improvement;

4. It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
5. It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
6. It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
7. It should recognize case mix differences in the patient population being treated within the practice.
8. It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
9. It should allow for additional payments for achieving measurable and continuous quality improvements.

Background of the Medical Home Concept

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving

patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

For More Information:

American Academy of Family Physicians

http://www.futurefamilymed.org

American Academy of Pediatrics:

http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians:

http://www.acponline.org/advocacy/?hp

American Osteopathic Association

http://www.osteopathic.org

CLOSING THE DIVIDE: HOW MEDICAL HOMES PROMOTE EQUITY IN HEALTH CARE

RESULTS FROM THE COMMONWEALTH FUND
2006 HEALTH CARE QUALITY SURVEY

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Katherine K. Shea, and Karen Davis

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ABSTRACT: The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a health care setting that provides patients with timely, well-organized care, and enhanced access to providers—racial and ethnic disparities in access and quality are reduced or even eliminated. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders. The results suggest that all providers should take steps to create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes for all patients.

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Editorial support was provided by Martha Hostetter.

EXECUTIVE SUMMARY

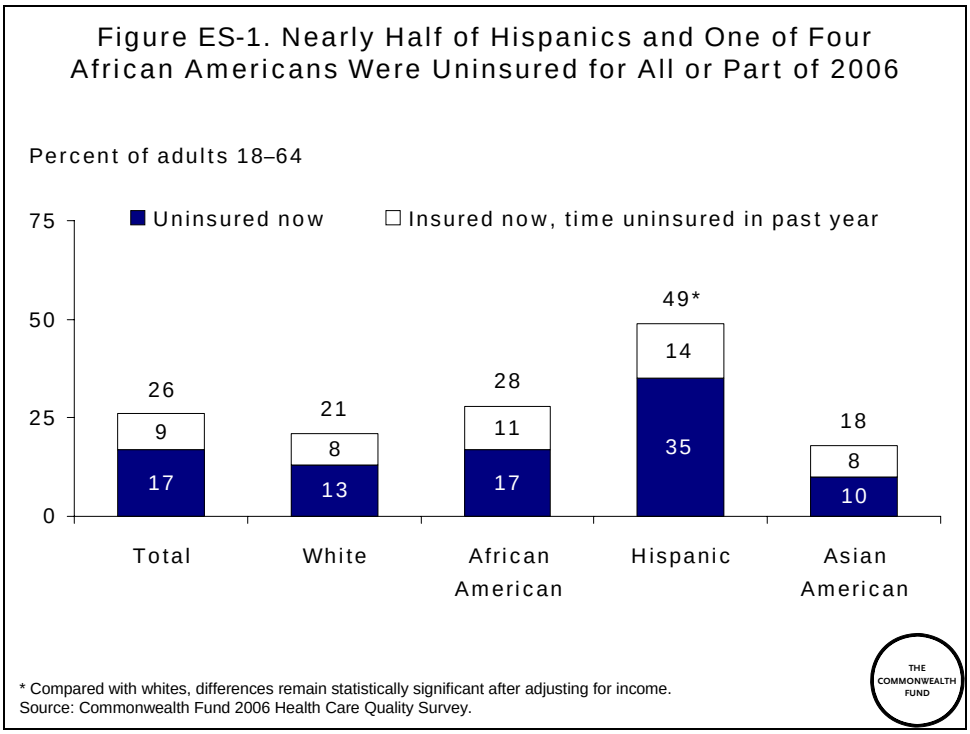
The Commonwealth Fund 2006 Health Care Quality Survey presents new information about interventions that show promise for promoting equity in health care and addressing racial and ethnic disparities in access to high-quality care. Findings from this survey are promising, as they suggest that racial and ethnic disparities are not immutable. Indeed, disparities in terms of access to and quality of care largely disappear when adults have a medical home, insurance coverage, and access to high-quality services and systems of care. The survey finds that, when adults have a medical home, their access to care and rates of preventive screenings improve substantially. Practice systems, in the form of patient reminders, also improve the quality of care for vulnerable patients by promoting higher rates of routine preventive screening.

The Commonwealth Fund Health Care Quality Survey, conducted among adults from May to October 2006, highlights how stable insurance, having a regular provider and, in particular, a medical home, improves health care access and quality among vulnerable populations. Over the past 20 years, much work has been done to identify and develop a set of indicators that best captures the components of a medical home. In this report, a medical home is defined as a health care setting that provides patients with timely, well-organized care and enhanced access to providers. Survey respondents who have a medical home report the following four features: they have a regular provider or place of care; they experience no difficulty contacting their provider by phone; they experience no difficulty getting care or advice on weekends or evenings; and they report that their office visits are always well organized and on schedule.

Following are some of the key findings of the survey.

Hispanics and African Americans are vulnerable: their uninsured rates are higher and they are less likely than whites to have access to a regular doctor or source of care.

- Among adults ages 18 to 64, nearly half of Hispanics (49%) and more than one of four African Americans (28%) were uninsured during 2006, compared with 21 percent of whites and 18 percent of Asian Americans (Figure ES-1).
- Hispanics and African Americans also have differential access to a regular doctor or source of care, with Hispanics particularly at risk. As many as 43 percent of Hispanics and 21 percent of African Americans report they have no regular doctor or source of care, compared with 15 percent of whites and 16 percent of Asian Americans.



By definition, a medical home provides patients with enhanced access to providers and timely, organized care.

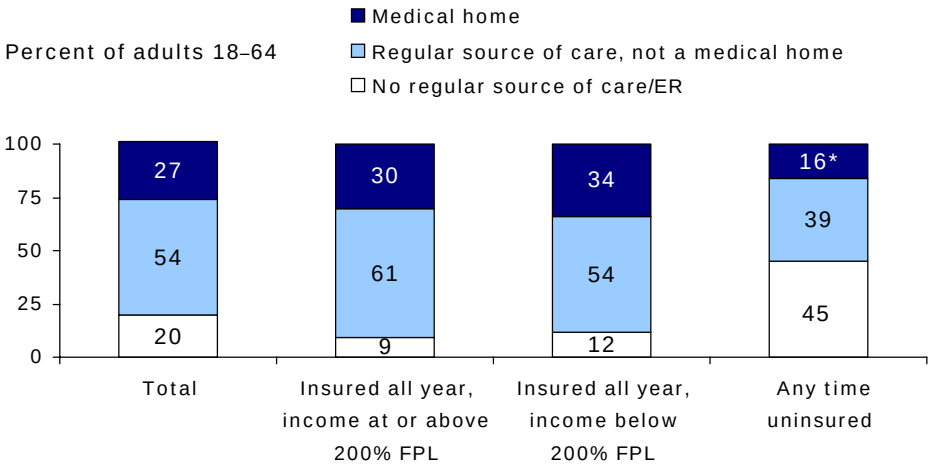
- Only 27 percent of adults ages 18 to 64 reported having all four indicators of a medical home: a regular doctor or source of care; no difficulty contacting their provider by telephone; no difficulty getting care or medical advice on weekends or evenings; and doctors' visits that are well organized and running on time (Figure ES-2).
- Many providers do not offer medical care or advice during evenings or weekends. Only two-thirds of adults who have a regular provider or source of care say that it is easy to get care or advice after hours. Compared with other populations, Hispanics are least likely to have access to after-hours care.
- Among adults who have a regular doctor or source of care, African Americans are most likely to have a medical home that provides enhanced access to physicians and well-organized care. One-third of African Americans (34%) have a medical home, compared with 28 percent of whites, 26 percent of Asian Americans, and just 15 percent of Hispanics.
- The uninsured are the least likely to have a medical home. Only 16 percent of the uninsured receive care through a medical home; 45 percent do not have a regular source of care (Figure ES-3).

Figure ES-2. Indicators of a Medical Home
(adults 18–64)

Indicator	Total		Percent by Race			
	Estimated millions	Percent	White	African American	Hispanic	Asian American
Regular doctor or source of care	142	80	85	79	57	84
Among those with a regular doctor or source of care . . .						
Not difficult to contact provider over telephone	121	85	88	82	76	84
Not difficult to get care or medical advice after hours	92	65	65	69	60	66
Doctors' office visits are always or often well organized and running on time	93	66	68	65	60	62
All four indicators of medical home	47	27	28	34	15	26

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure ES-3. Uninsured Are Least Likely to Have a Medical Home and Many Do Not Have a Regular Source of Care

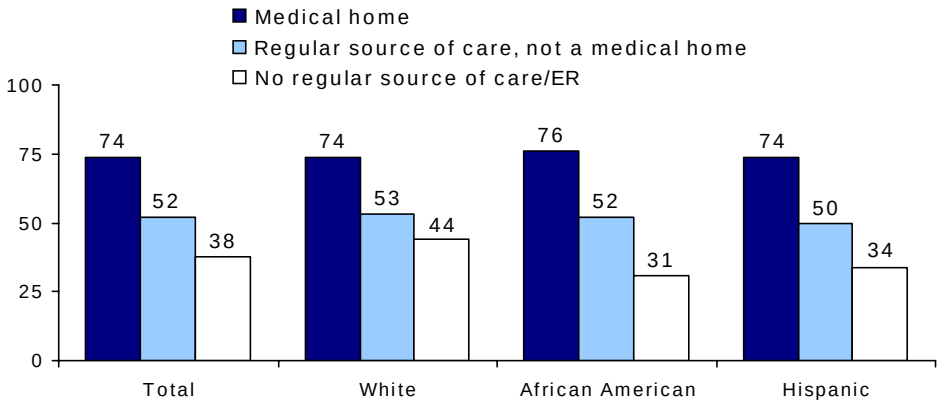


Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with insured with income at or above 200% FPL, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Medical homes reduce disparities in access to care.

- The vast majority (74%) of adults with a medical home always get the care they need, compared with only 52 percent of those with a regular provider that is not a medical home and 38 percent of adults without any regular source of care or provider.
- When minorities have a medical home, racial and ethnic differences in terms of access to medical care disappear. Three-fourths of whites, African Americans, and Hispanics with medical homes reported getting the care they need when they need it (Figure ES-4).

Figure ES-4. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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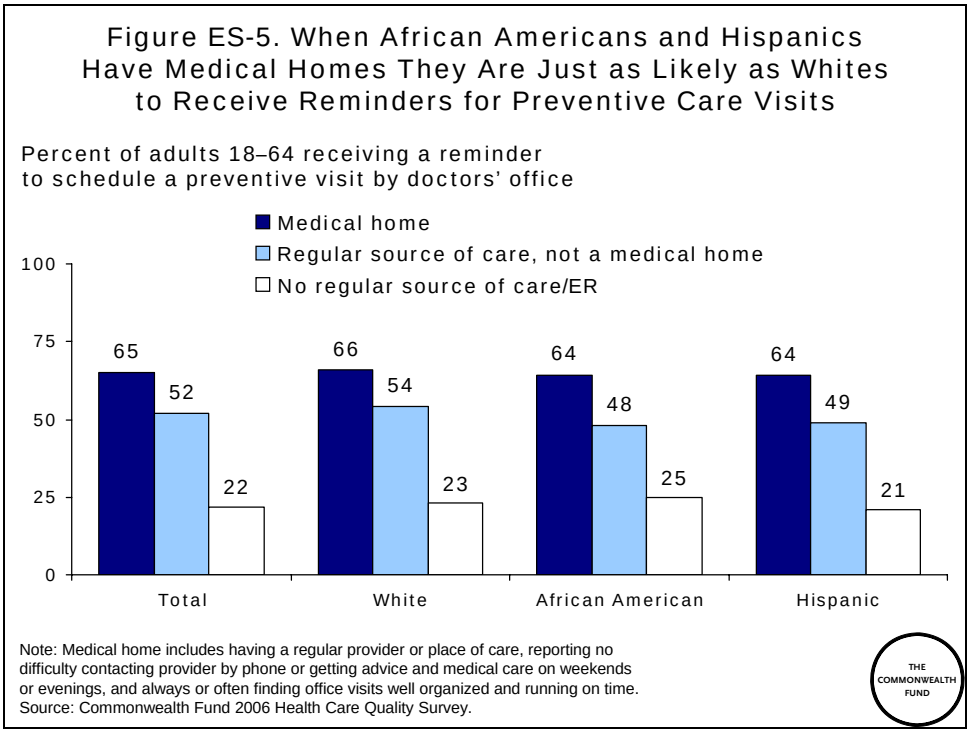
Use of reminders for preventive care is associated with higher rates of preventive screening. Among patients with medical homes, there are no racial disparities in terms of receipt of preventive care reminders.

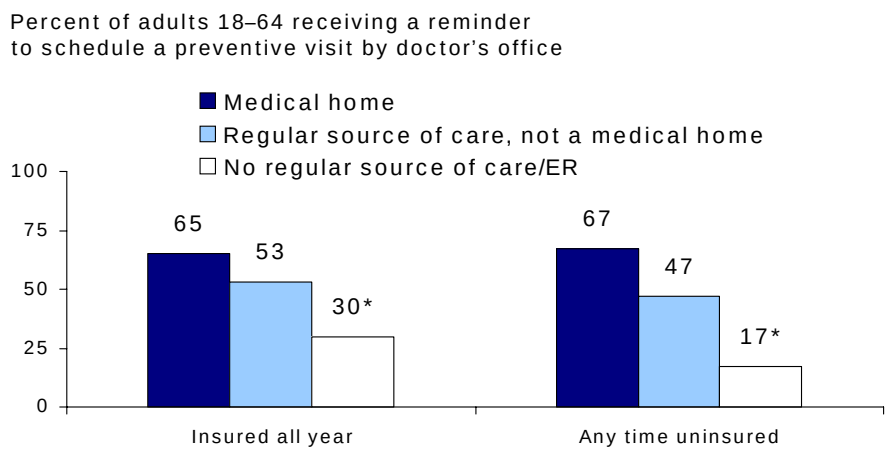
- The use of reminders substantially increases the rates of routine preventive screenings, such as cholesterol screening, breast cancer screening, and prostate cancer screening. Eight of 10 (82%) adults who received a reminder had their cholesterol checked in the past five years, compared with half of adults who did not get a reminder.
- Men who received a reminder were screened for prostate cancer at twice the rate (70%) as those who did not get a reminder (37%).

- When minorities have a medical home, their access to preventive care improves substantially. Regardless of race or ethnicity, about two-thirds of all adults who have a medical home receive preventive care reminders (Figure ES-5).



- More than half of insured adults (54%) received a reminder from a doctors' office to schedule a preventive visit, compared with only 36 percent of uninsured adults. When minority populations are insured, they are just as likely as white adults to receive reminders to schedule preventive care.
- Even among the uninsured, having a medical home affects whether patients receive preventive care reminders. Two-thirds of both insured and uninsured adults with medical homes receive preventive care reminders, compared with half of insured and uninsured adults without medical homes (Figure ES-6).

Figure ES-6. Patients with Medical Homes—Whether Insured or Uninsured—Are Most Likely to Receive Preventive Care Reminders



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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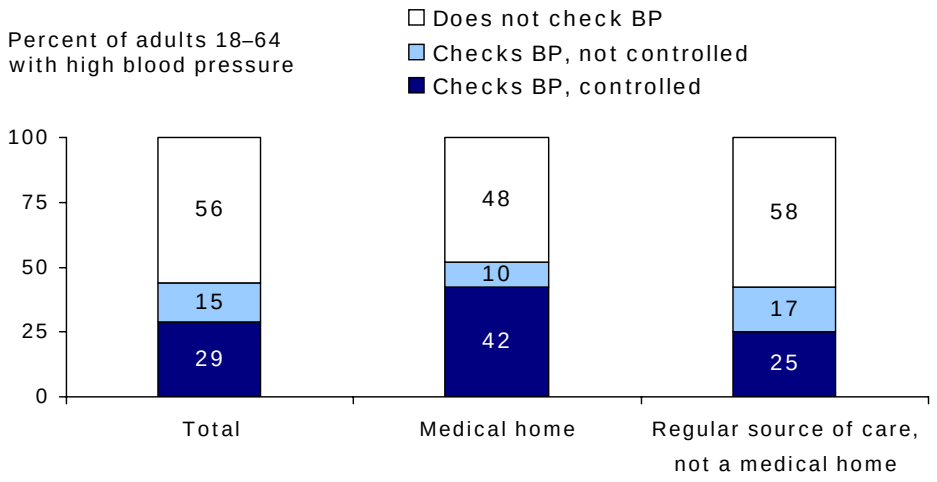
Adults with medical homes are better prepared to manage their chronic conditions—and have better health outcomes—than those who lack medical homes.

- The survey finds that adults who have medical homes are better prepared to manage their chronic conditions. Only 23 percent of adults with a medical home report their doctor or doctor's office did not give them a plan to manage their care at home, compared with 65 percent of adults who lack a regular source of care.
- Among hypertensive adults, 42 percent of those with a medical home reported that they regularly check their blood pressure and that it is well controlled. Only 25 percent of hypertensive adults with a regular source of care, but not a medical home, reported this (Figure ES-7).
- Adults with a medical home reported better coordination between their regular providers and specialists. Among those who saw a specialist, three-fourths said their regular doctor helped them decide whom to see and communicated with the specialist about their medical history, compared with 58 percent of adults without a medical home.

Figure ES-7. Adults with a Medical Home Are More Likely to Report Checking Their Blood Pressure Regularly and Keeping It in Control



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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Community health centers and public clinics—which care for many uninsured, low-income, and minority adults—are less likely than private doctors' offices to have features of a medical home.

- The survey finds that community health centers or public clinics serve 20 percent of the uninsured and 20 percent of low-income adults with coverage. In addition, 13 percent of African Americans and more than one of five Hispanics named community health centers or public clinics as their regular source of care.

- Patients who use community health centers or public clinics as their usual source of care are less likely than those who use private doctors' offices to have a medical home. Only 21 percent of adults using community health centers or public clinics reported that they have a regular doctor, have no difficulty contacting their provider by telephone or getting care or medical advice on weekends or evenings, and reported that their doctors' visits are always well organized and running on time. In contrast, 32 percent of patients who use private doctors' offices reported all features of a medical home. Difficulty getting medical advice or care in the evenings or on weekends is more pervasive in community health centers and public clinics than in private doctors' offices or clinics (Figure ES-8).

Figure ES-8. Indicators of a Medical Home
by Usual Health Care Setting
(adults 18–64)

		Usual Health Care Setting		
Indicator	Total	Doctors' office	Community health center or public clinic	Other settings*
Regular doctor or source of care	80%	95%	78%	63%
Among those with a regular doctor or source of care . . .				
Not difficult to contact provider over telephone	85	87	77	77
Not difficult to get care or medical advice after hours	65	67	54	69
Always or often find visits to doctors' office well organized and running on time	66	68	56	60
All four indicators of a medical home	27	32	21	22

* Includes hospital outpatient departments and other settings.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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CONCLUSIONS

The Commonwealth Fund Health Care Quality Survey finds that, when patients have a medical home, racial and ethnic disparities in terms of access to and quality of care are reduced or eliminated. The survey results suggest that all providers should take steps to help create medical homes for patients. Community health centers and other public clinics, in particular, should be supported in their efforts to build medical homes, as they care for patients regardless of ability to pay. Improving the quality of health care delivered by safety net providers can have a significant impact on disparities by promoting equity and ensuring access to high-quality care.

In addition, the promotion of medical homes, including the establishment of standards, public reporting of performance, and rewards for achieving excellence, would support improvement in the delivery of health care services in all settings.

CLOSING THE DIVIDE:
HOW MEDICAL HOMES PROMOTE EQUITY IN HEALTH CARE

INTRODUCTION: THE IMPORTANCE OF HAVING INSURANCE COVERAGE AND A MEDICAL HOME

Racial and ethnic minorities are more likely than whites to have low incomes and be in poor health. Lack of health insurance and lack of access to a regular source of care are key contributors to racial and ethnic health care disparities.[1] Previous Fund reports have demonstrated that uninsured rates for Hispanic and African American adults are one-and-a-half to three times greater than the rate for white adults.[2] In addition, Hispanics are particularly disconnected from the health care system, being substantially less likely than whites to have a regular doctor, to have visited a doctor in the past year, or to feel confident about their ability to manage their health problems. African Americans also have more problems with access to care and are significantly more likely than whites to visit the emergency room for non-urgent care and to experience serious problems dealing with medical bills and medical debt.[3]

Yet, even when minority adults have access to the health care system, they receive lower-quality care for many conditions and report receiving less respect for their personal preferences, compared with white patients.[4]

"Medical homes" are one model for expanding access and delivering high-quality care. A medical home is more than just a regular place to receive health care; it is a comprehensive approach to providing accessible, organized primary care. The concept of a medical home was first introduced by the American Academy of Pediatrics and has been described as a place where health care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.[5] In medical home practices, patients develop relationships with their providers and work with them to maintain a healthy lifestyle and coordinate preventive and ongoing health services.[6] Over the past 20 years, much work has been done to identify and develop a set of indicators that captures the components of a medical home.[7]

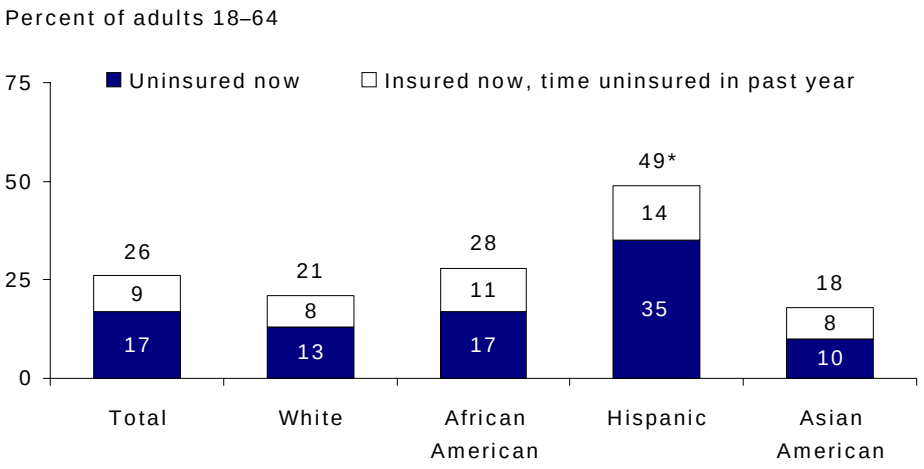
The Commonwealth Fund 2006 Health Care Quality Survey finds that health care settings with features of a medical home—those that offer patients a regular source of care, enhanced access to physicians, and timely, well-organized care—have the potential to eliminate disparities in terms of access to quality care among racial and ethnic minorities. This suggests that expanding access to medical homes could improve quality and increase equity in the health care system.

The survey was conducted among a random, nationally representative sample of 3,535 adults age 18 and older living in the continental United States. This report is based on analysis of responses from non-elderly adults ages 18 to 64; respondents are classified by whether they have a regular doctor or place of care, whether their place of care is a medical home, or whether they have neither a medical home nor a regular place of care. Where the sample size permits, the analysis highlights differences in outcomes by racial and ethnic groups as well as by insurance and poverty status (see Appendix B. Survey Methodology for more detail).

INSURANCE COVERAGE AMONG AFRICAN AMERICAN AND HISPANIC ADULTS

Uninsured rates in 2006 remained high for African Americans and Hispanics. Among working-age adults ages 18 to 64, nearly half of Hispanics (49%) and 28 percent of African Americans were uninsured during the year, compared with 21 percent of whites and 18 percent of Asian Americans (Figure 1). African Americans and Hispanics are more likely than whites and Asian Americans to be uninsured, in large part because they are less likely to get coverage through their employers. Indeed, although most African Americans and Hispanics live in families in which at least one member is working, rates of continuous health coverage are lower for these minority groups, particularly for Hispanics. Only about half of Hispanics (53%) in families with at least one full-time worker were insured all year, compared with 82 percent of whites and 75 percent of African Americans (Figure 2). Just 43 percent of working-age Hispanics and 54 percent of African Americans have employer-based insurance, compared with 68 percent of whites and 71 percent of Asian Americans (Figure 3).

Figure 1. Nearly Half of Hispanics and One of Four African Americans Were Uninsured for All or Part of 2006



* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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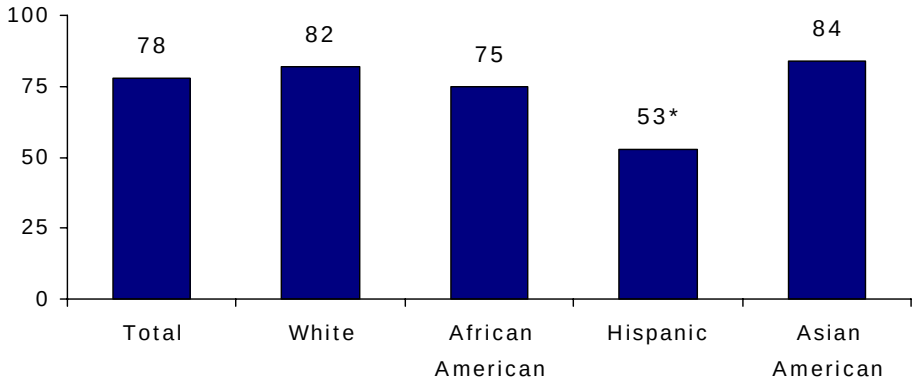
Figure 2. Hispanics Are Least Likely to Have Continuous Insurance Coverage Even When a Family Member Has Full-Time Employment



* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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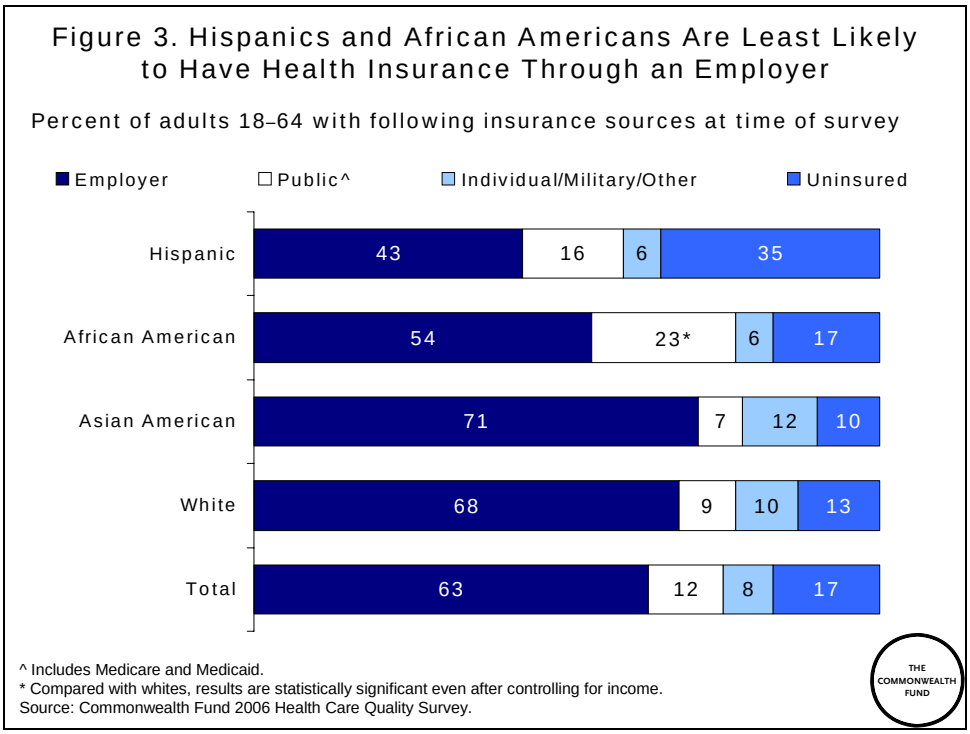
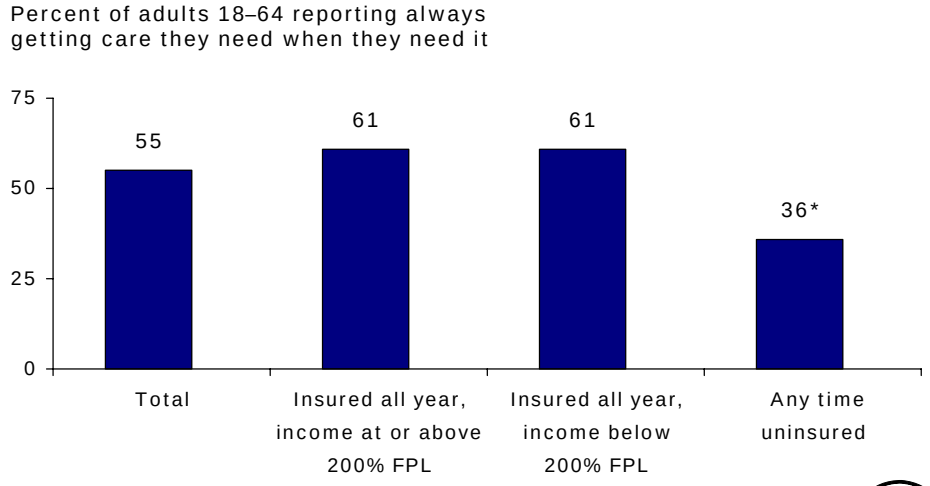


Insurance coverage reduces disparities among low-income and minority adults. Lack of insurance coverage is a persistent problem for low-income adults as well as racial and ethnic minorities, and health insurance is a critical factor in determining whether people have timely access to appropriate care across a range of preventive, chronic, and acute care services. Sixty-one percent of insured adults reported being able to get the care they need, compared with 36 percent of uninsured adults (Figure 4).

Building on previous research demonstrating the role of health insurance in facilitating access to timely care, this survey finds that expanding coverage would benefit the most vulnerable populations; in fact, some disparities in health care access and utilization could be reduced or even eliminated.[8] Survey findings indicate that, when minority populations are insured, they are just as likely as white adults to receive many important preventive care interventions. For example, more than half of insured adults (54%) receive a reminder from a doctors' office to schedule preventive visits, compared with only 36 percent of uninsured adults. When insured, minorities receive preventive care reminders at similar rates as whites (Figure 5).

Figure 4. Uninsured Are Less Likely to Report Always Getting the Care They Need When They Need It; Low-Income Adults, When Insured, Are as Satisfied as Higher-Income Adults



* Compared with insured with income at/above 200% poverty, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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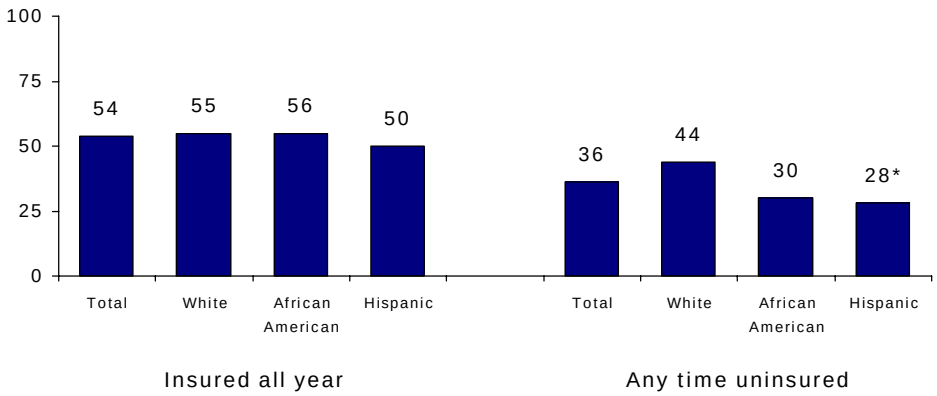
Figure 5. When Insured, Minorities Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits; Rates Are Low for All Uninsured Adults, Especially Hispanics



* Compared with whites, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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ACCESS TO A MEDICAL HOME

Hispanics and African Americans are more likely to be uninsured—and to lack access to a medical home. Just as Hispanics and African Americans are more likely than whites and Asian Americans to lack health coverage, they also are more likely to lack access to a regular doctor or source of care. Hispanics are particularly at risk. As many as 43 percent of Hispanics and 21 percent of African Americans reported they have no regular doctor or source of care, compared with 15 percent of whites and 16 percent Asian Americans (Figure 6).

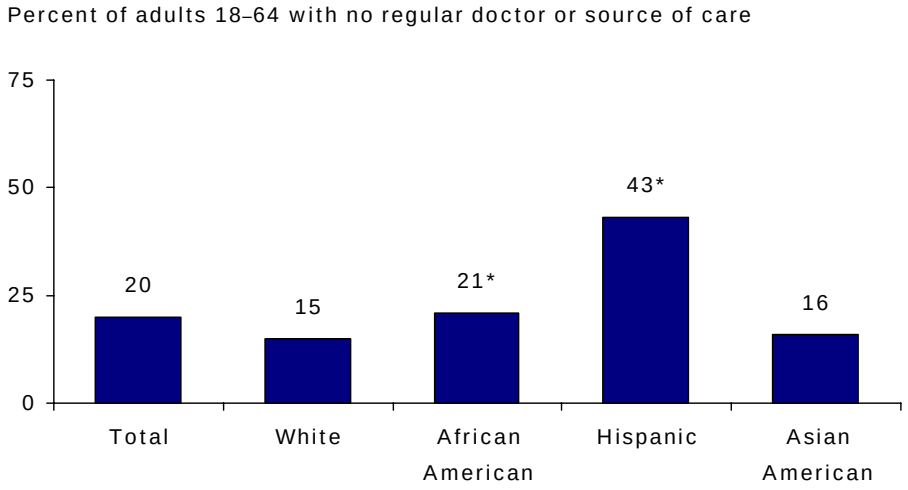
Beyond basic access to a regular provider, the survey studied the impact of having access to an enhanced regular provider—that is, access to a medical home. The survey used the following four indicators to measure the extent to which adults have a medical home: 1) having a regular doctor or place of care, 2) experiencing no difficulty contacting their provider by telephone; 3) experiencing no difficulty getting care or medical advice on weekends or evenings; and 4) having doctors' office visits that are well organized and running on time (Figure 7).

By definition, a medical home provides patients with better access to physicians and well-organized care. The majority of respondents who have a regular source of care can contact their providers by phone. Yet, many providers do not offer medical care or advice during evenings or weekends. Only two-thirds of adults (65%) who have a regular provider or source of care reported that it is easy to get care or medical advice after hours. Among patient groups, Hispanics are least likely to be able to get care or advice after hours and African Americans are the most likely to be able to do so. Another 66 percent of adults with a regular provider or source of care reported that their doctor visits are always or often organized and running on time, with white adults the most likely to have reported this and Hispanics and Asian Americans the least likely.

When all four characteristics of a medical home are combined, only 27 percent of working-age adults—an estimated 47 million people—have a medical home (Figure 8). Another 54 percent of adults have a regular doctor or source of care, but they do not have the enhanced access to care provided by a medical home. The remaining 20 percent of adults have no regular doctor or source of care. Among patient groups, African Americans are most likely and Hispanics are least likely to have a medical home that provides enhanced access to physicians and well-organized care. One-third of African Americans (34%) have a medical home, compared with 28 percent of whites, 26 percent of Asian Americans, and just 15 percent of Hispanics.

Having insurance coverage is a strong predictor of whether adults have a medical home or a regular source of care (Figure 8). Only 16 percent of adults who were uninsured during the year have a medical home. By comparison, 30 percent of insured adults with incomes twice the poverty level or higher, and an even greater proportion of insured, low-income adults (34%), have a medical home (Figure 9). Most vulnerable are the 45 percent of uninsured adults—an estimated 21 million people—who do not have a regular source of care. There are also a fair number of uninsured adults (39%) who have a regular source of care, but nonetheless lack the enhanced access to providers available in a medical home. Among this group of uninsured patients, nearly one of three (28%) uses community health centers or public clinics and 61 percent use doctors' offices for their care (data not shown).

Figure 6. Hispanics Are Most Likely to Be Without a Regular Doctor or Source of Care



* Compared with whites, differences remain statistically significant after adjusting for age, income, and insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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Figure 7. Indicators of a Medical Home
(adults 18–64)

Indicator	Total		Percent by Race			
	Estimated millions	Percent	White	African American	Hispanic	Asian American
Regular doctor or source of care	142	80	85	79	57	84
Among those with a regular doctor or source of care . . .						
Not difficult to contact provider over telephone	121	85	88	82	76	84
Not difficult to get care or medical advice after hours	92	65	65	69	60	66
Doctors' office visits are always or often well organized and running on time	93	66	68	65	60	62
All four indicators of medical home	47	27	28	34	15	26

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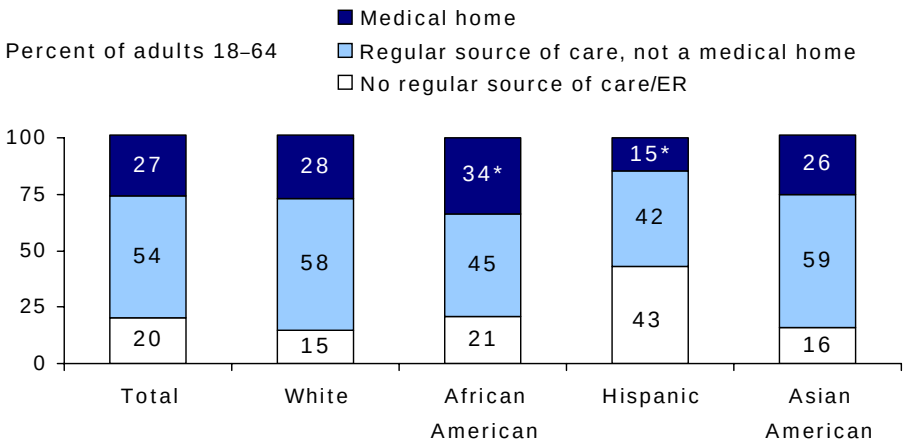
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 8. African Americans and Hispanics Are More Likely to Lack a Regular Provider or Source of Care; Hispanics Are Least Likely to Have a Medical Home



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with whites, differences remain statistically significant after adjusting for income and insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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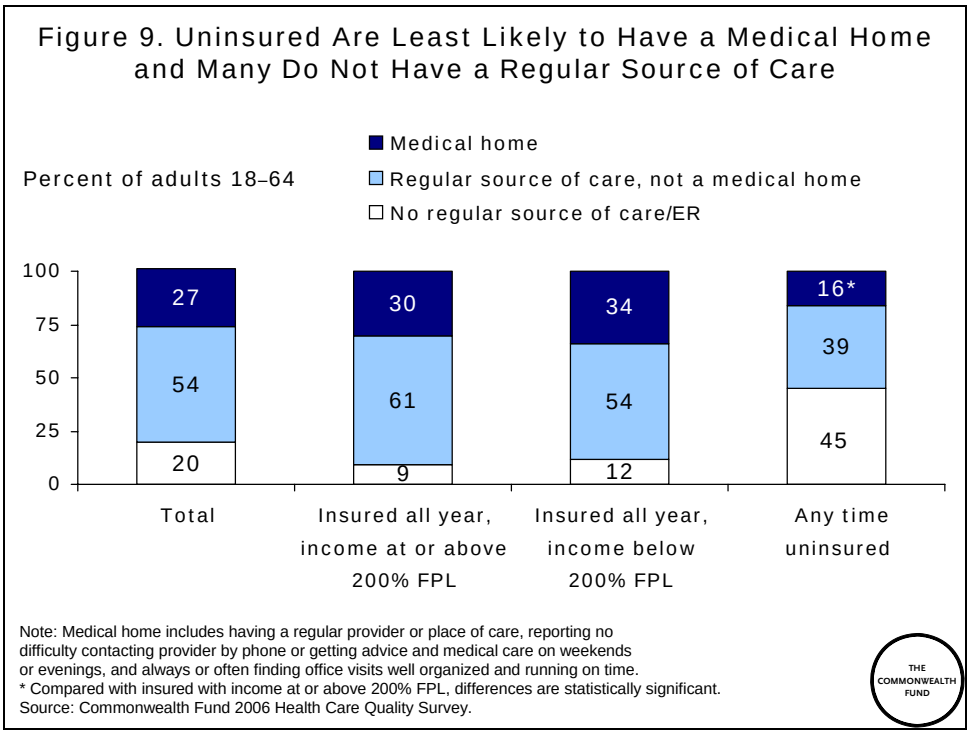


TIMELY RECEIPT OF NEEDED CARE AND PREVENTIVE SERVICES

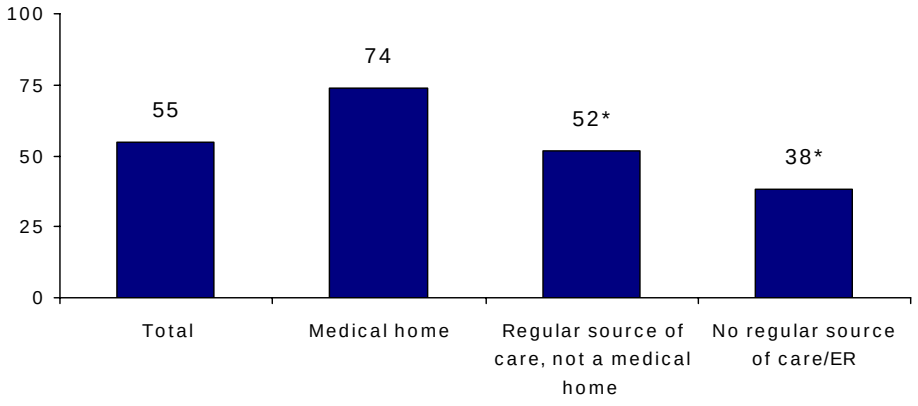
Asian Americans and Hispanics have more difficulty accessing timely and needed care. The survey asked respondents to rate their ability to get needed medical care. Specifically, respondents were asked, "When you think about your health care in general, how often do you receive the health care you need when you need it?"[9] Findings show that just over half of adults (55%) said they always get the care they need (Table 2). Asian Americans and Hispanics were least likely to have reported always being able to get needed care: less than half of Hispanics (46%) and Asian Americans (48%) reported this, compared with 57 percent of whites and 56 percent of African Americans. Waiting times to get medical appointments also differ significantly by race/ethnicity. Hispanic and Asian Americans were less likely to report rapid access to medical appointments (i.e., same- or next-day appointments) and more likely to report waits of six days or more (Table 2). Over one-quarter (26%) of Hispanics and 18 percent of Asian Americans had to wait six days or longer to get a medical appointment, compared with 14 percent of whites.

Medical homes eliminate racial and ethnic differences in receipt of timely medical care. Whether adults have medical homes significantly affects whether they can get the care they need, when they need it. Moreover, racial and ethnic differences in terms of timely access to care are eliminated when adults have medical homes. The vast majority (74%) of adults with a medical home reported always getting the

care they need, compared with only 52 percent of adults who have a regular provider but not a medical home and just 38 percent of adults without any regular source of care or provider (Figure 10). Minorities, particularly Hispanics and Asian Americans, were less likely to report always getting the care they need (Figure 11). However, when minorities have a medical home, they are as likely as whites to get the care they need and have rapid access to medical appointments. Three-fourths of whites, African Americans, and Hispanics with medical homes reported getting the care they need when they need it (Figure 12).

Adults who do not have a medical home are at a significant disadvantage when seeking rapid access to medical appointments. The vast majority of adults with a medical home (76%) can get same- or next-day appointments, whereas only 62 percent of those who have a regular provider but not a medical home and 43 percent of those without any regular provider can do so. Indeed, no racial or ethnic disparities remain in terms of rapid access to medical appointments among adults with medical homes (Figure 13). Regardless of race or ethnicity, three-fourths of all adults with a medical home have rapid access to medical appointments. Among adults with no regular source of care, there are no differences among patient groups in terms of the ability to get same- or next-day appointments.

Figure 10. The Majority of Adults with a Medical Home Always Get the Care They Need



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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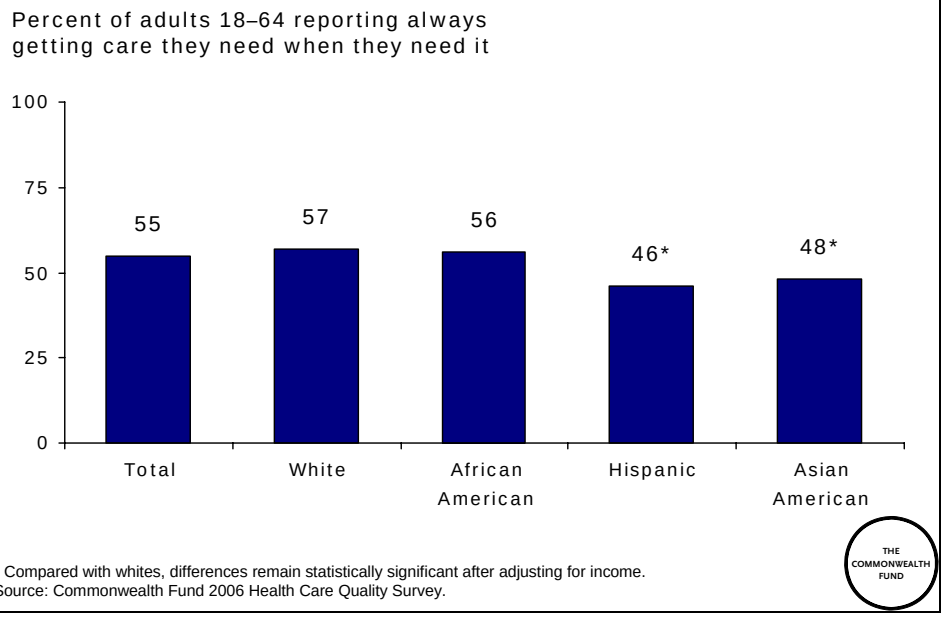
Figure 11. Hispanics and Asian Americans Are Less Likely to Report Always Getting Medical Care When Needed



* Compared with whites, differences remain statistically significant after adjusting for income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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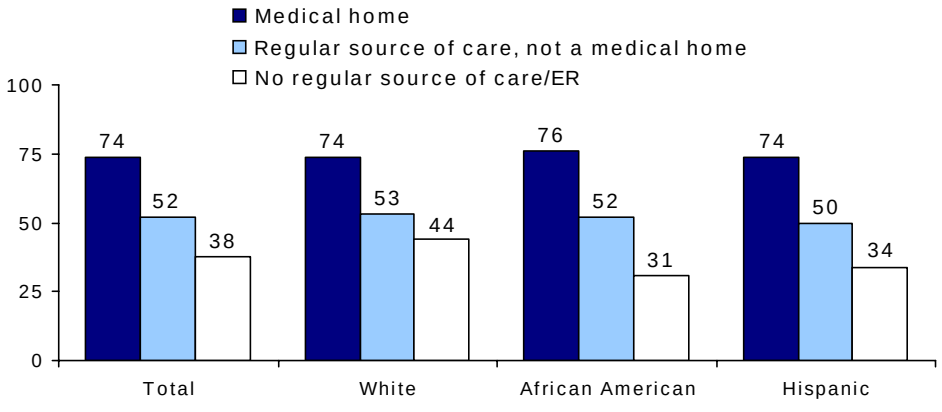
Figure 12. Racial and Ethnic Differences in Getting Needed Medical Care Are Eliminated When Adults Have Medical Homes



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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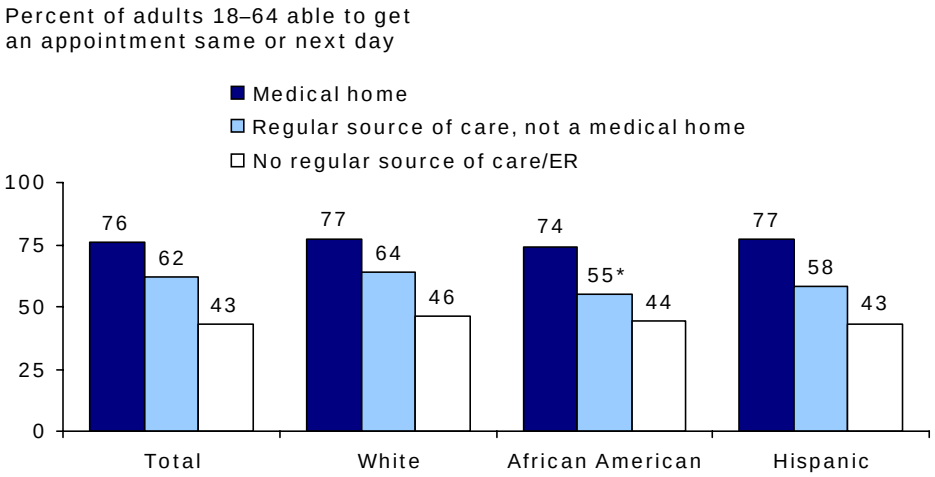
Figure 13. African American and Hispanic Adults Who Have Medical Homes Have Rapid Access to Medical Appointments



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with whites, differences are significant within category of medical home.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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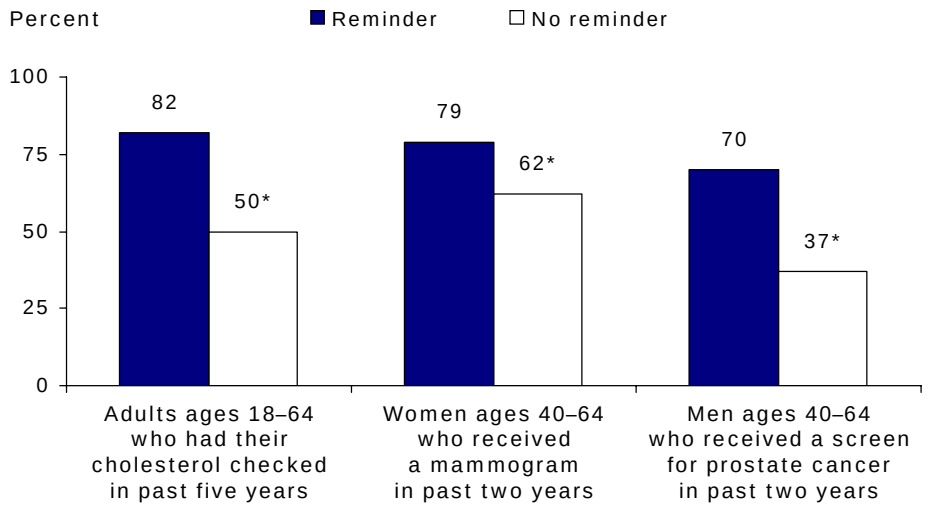
Reminders sent by doctors are associated with higher rates of routine preventive care; medical homes are more likely to send reminders. Providers can encourage patients to seek routine preventive care by sending them reminders to make appointments for preventive care visits. The survey findings show that preventive care reminders are associated with substantially higher rates of routine preventive screening. For example, adults who receive reminders have significantly higher rates of cholesterol screenings than those who do not receive reminders (82% vs. 50%). A similar pattern is evident for breast cancer screening (79% vs. 62%) and prostate cancer screening (70% vs. 37%) (Figure 14).

The survey finds that adults who have a medical home are significantly more likely to receive reminders from their doctor and get recommended preventive screening. Nearly two-thirds of adults with a medical home receive reminders for preventive care, but just half of adults (52%) with a regular provider that is not a medical home, and only 22 percent of adults without a regular source of care, receive such reminders (Figure 15). About half of all adults receive preventive care reminders from their providers. Yet, just 39 percent of Hispanics and 37 percent of Asian Americans receive such reminders, compared with about half of African American (49%) and white (53%) adults (Figure 16). Yet, when they have a medical home, minorities are just as likely as whites to receive reminders for preventive care visits (Figure 17).

Figure 14. Adults Who Are Sent Reminders Are More Likely to Receive Preventive Screening



* Compared with reminders, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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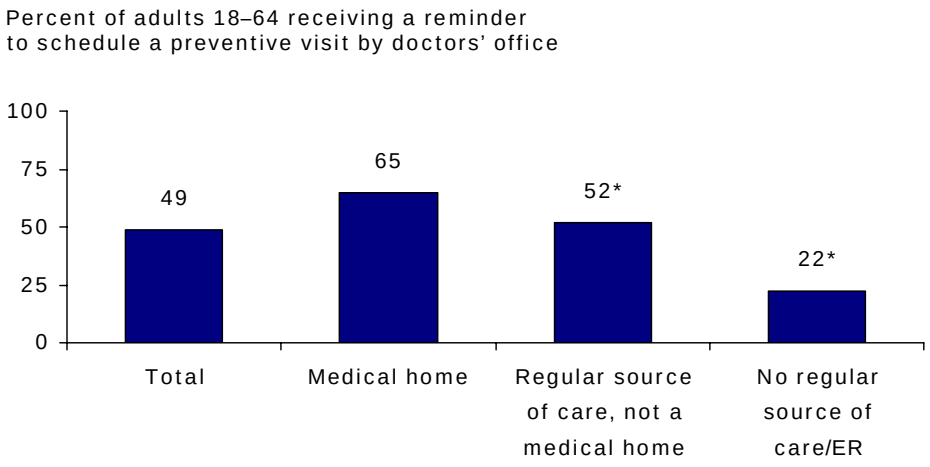
Figure 15. Nearly Two-Thirds of Adults with Medical Homes Receive Reminders for Preventive Care



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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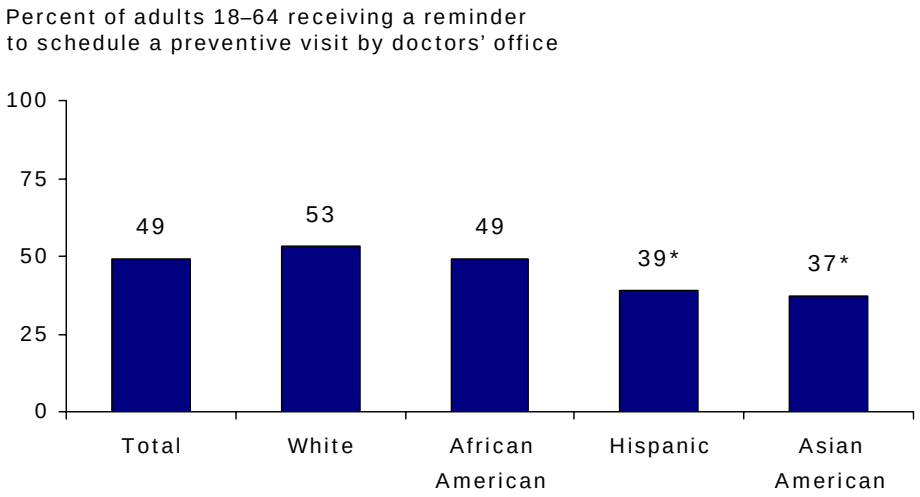
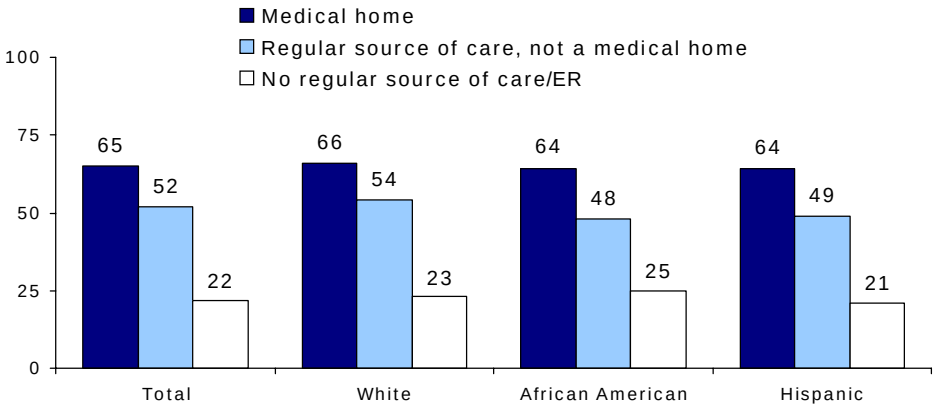
Figure 16. Hispanics and Asian Americans Are Less Likely to Receive a Reminder for Preventive Care Visits



* Compared with whites, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 17. When African Americans and Hispanics Have Medical Homes They Are Just as Likely as Whites to Receive Reminders for Preventive Care Visits



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

When minorities have medical homes, their use of preventive care increases and disparities narrow. Adults with no regular provider or source of care are at great risk for not getting recommended preventive tests. The majority of adults (76%) with a medical home reported getting their cholesterol checked in the past five years,

compared with only one-third (34%) of adults without a regular provider or source of care (Figure 18). Those with a medical home also reported higher rates of prostate cancer screening: nearly four of five (77%) men with a medical home were screened for prostate cancer, compared with only 47 percent of men who have a regular provider but not a medical home and 34 percent of men without a regular provider or source of care (Table 2). Clearly, adults who do not have a medical home or lack a regular source of care are at a great disadvantage when it comes to receiving optimal preventive care.

Rates of receipt of preventive care reminders, as well as preventive services such as cholesterol and cancer screening, are particularly low among Hispanics. Slightly more than half (56%) of Hispanics reported having their cholesterol checked in the past five years, compared with 67 percent of whites, 63 percent of African Americans, and 62 percent of Asian Americans (Figure 19). Prostate cancer screening rates are even lower—just two of five (39%) Hispanic men were screened for prostate cancer, compared with half or more of white, African American, and Asian American men (Table 2). When Hispanics have a medical home, their access to preventive care improves substantially, and these disparities are reduced or eliminated. Indeed, regardless of race or ethnicity, cholesterol screening rates improve for all adults with a medical home. In fact, when Hispanic adults have a medical home, they are just as likely as white adults to have their cholesterol screened (Figure 20). Three of four (75%) whites with a medical home had a cholesterol screening, as did 73 percent of African Americans and 69 percent of Hispanics with medical homes.

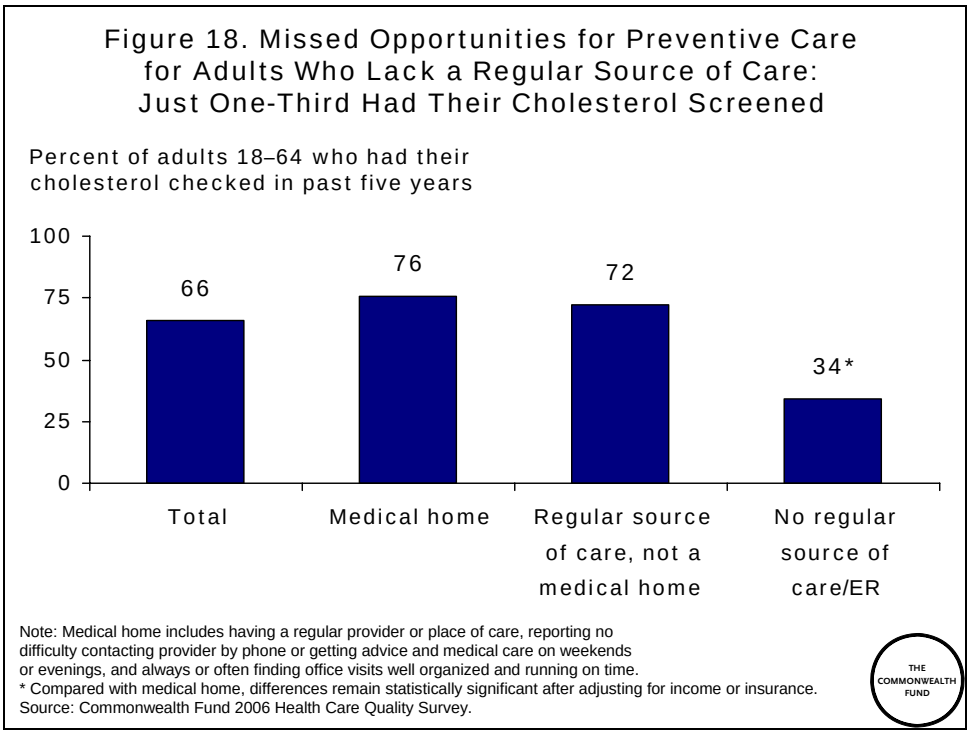
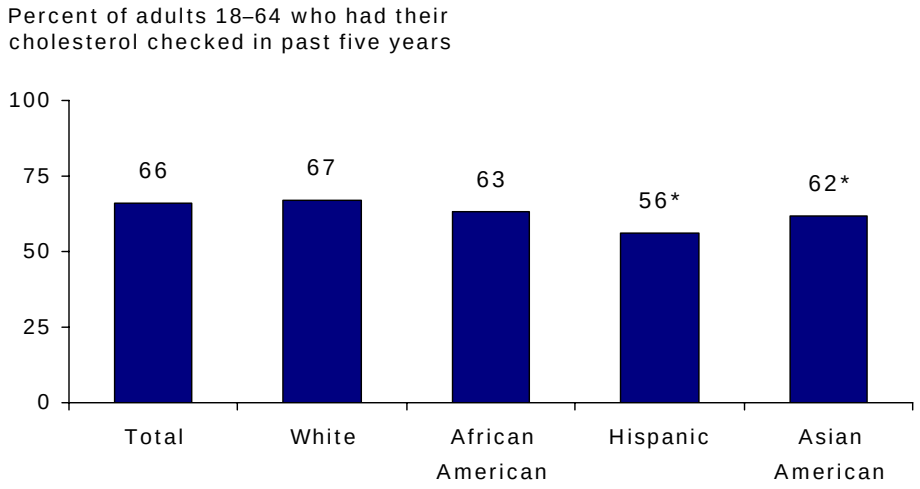


Figure 19. Hispanics and Asian Americans Are Less Likely to Have Their Cholesterol Checked



* Compared with whites, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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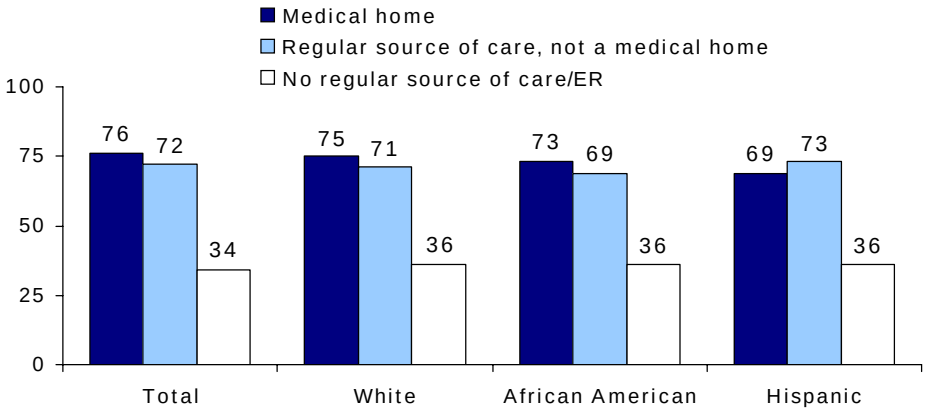
Figure 20. African Americans and Hispanics with Medical Homes Are Equally as Likely as Whites to Receive Cholesterol Checks



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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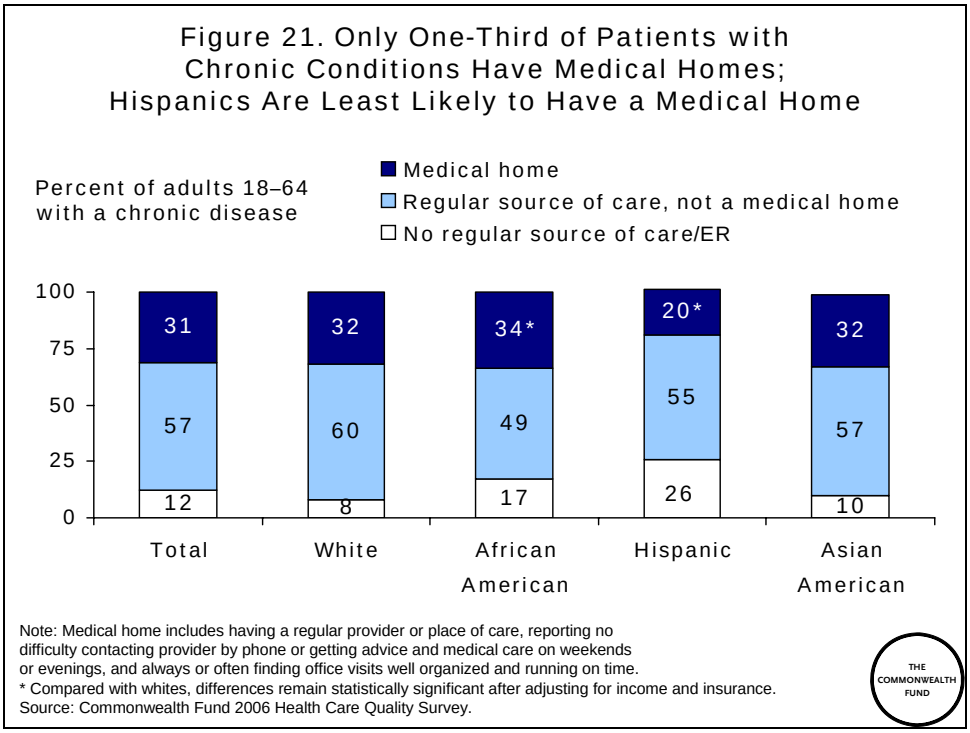
MANAGEMENT OF CHRONIC CONDITIONS

Prevalence of chronic conditions and access to a medical home. To be effective, a health system needs to be able to manage care for patients with chronic medical conditions. The survey finds that, among patient groups, African Americans have the

highest prevalence of chronic conditions, including high blood pressure, diabetes, asthma or emphysema, and heart disease. Forty-three percent of African Americans have at least one chronic condition, compared with 35 percent of whites, 24 percent of Hispanics, and 22 percent of Asian Americans (Table 4). Among all populations, an estimated 59.5 million working-age adults have medical needs, or chronic conditions, that require continuous access to high-quality health systems.

For patients, successfully managing a chronic condition requires an ongoing relationship with a medical provider who can partner with them and coordinate their care. Many chronic conditions, such as diabetes and hypertension, require a great deal of management through diet, exercise, and monitoring. However, among all adults with a chronic condition, less than one-third reported having a medical home to support them in management of their conditions. The survey uncovered racial differences on this measure: among those with chronic conditions, Hispanics are the least likely to have medical homes (20%) compared with whites (32%), Asian Americans (32%), and African Americans (34%) (Figure 21).



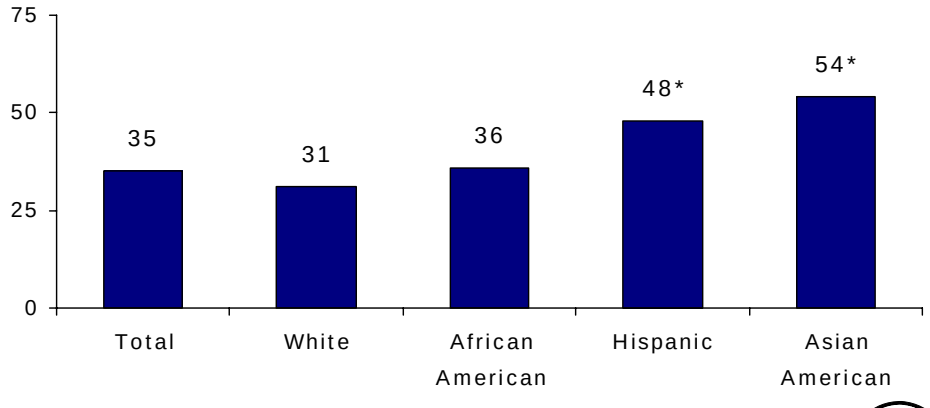
Hispanics and Asian Americans with chronic conditions are least likely to be given adequate support to manage their conditions. The survey finds that more than one of three adults with chronic conditions are not given adequate support to manage their conditions. Over half (54%) of Asian Americans and 48 percent of Hispanics reported they were not given a plan to manage their care at home, compared with 36 percent of African Americans and 31 percent of whites (Figure 22). As a result, many

adults are not confident that they can manage their health conditions. Among Hispanics with chronic conditions, only 57 percent said they are very confident, while 62 percent of Asian Americans, 63 percent of African Americans, and 72 percent of whites reported being very confident (Table 3).

Adults who have a medical home reported better management of their chronic conditions, beginning with receipt of self-management plans. Less than one of four adults (23%) with chronic conditions in medical homes reported they did not receive a plan to manage their condition. In contrast, 35 percent of adults with a regular provider that is not a medical home did not receive such a plan, while 65 percent of adults without a regular provider did not receive such a plan (Figure 23).

Counseling on diet and exercise is critically important for adults with many chronic conditions, including hypertension and diabetes. Adults with these conditions are often overweight or obese, which contributes to the severity of their conditions. Overweight or obese adults who have a regular source of care are more likely to receive counseling on diet and exercise than those with no regular source of care. What's more, providers counsel the uninsured at similar rates as they counsel the insured, although there are some persistent differences. Among adults with a medical home, 80 percent of the insured receive counseling, compared with 65 percent of the uninsured. Among adults with a regular provider that is not a medical home, 73 percent of the insured are counseled, versus 69 percent of the uninsured (Figure 24).

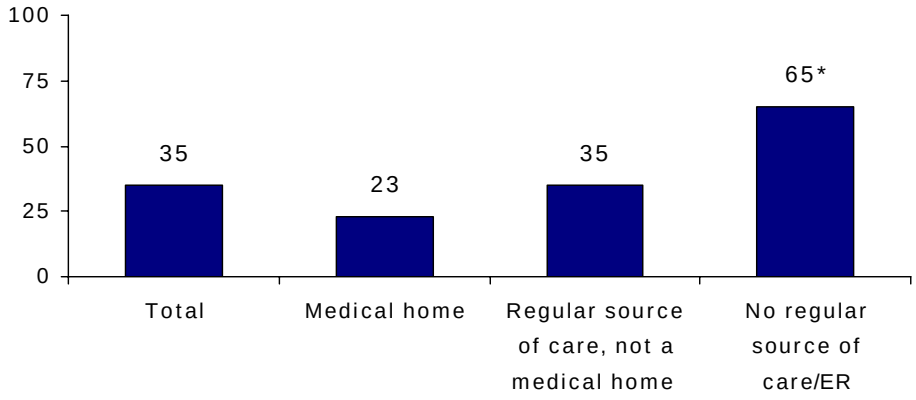
Figure 22. About Half or More of Hispanics and Asian Americans with Chronic Conditions Were Not Given Plans to Manage Their Condition at Home



* Compared with whites, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 23. Less than One-Quarter of Adults with Medical Homes Did Not Receive Plans to Manage Their Conditions at Home

Percent of adults ages 18–64 with any chronic condition who were *not* given a plan from a doctor or nurse to manage condition at home



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences remain statistically significant after adjusting for income or insurance.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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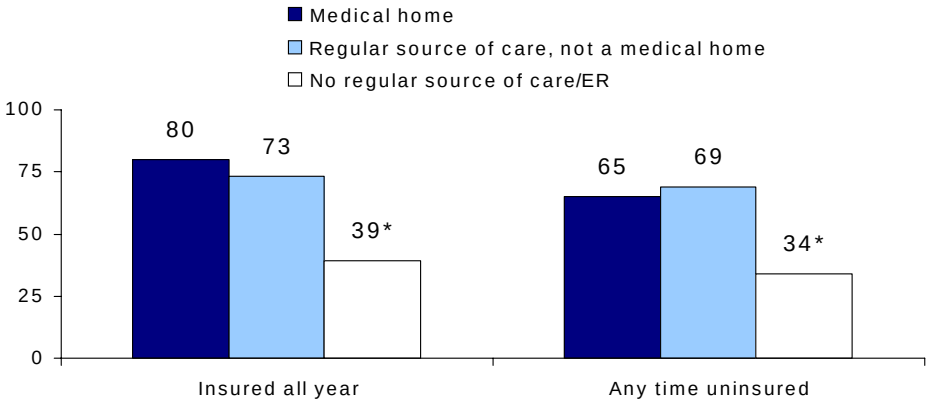
Figure 24. Adults with a Medical Home Have Higher Rates of Counseling on Diet and Exercise Even When Uninsured

Percent of obese or overweight adults 18–64 who were counseled on diet and exercise by doctor



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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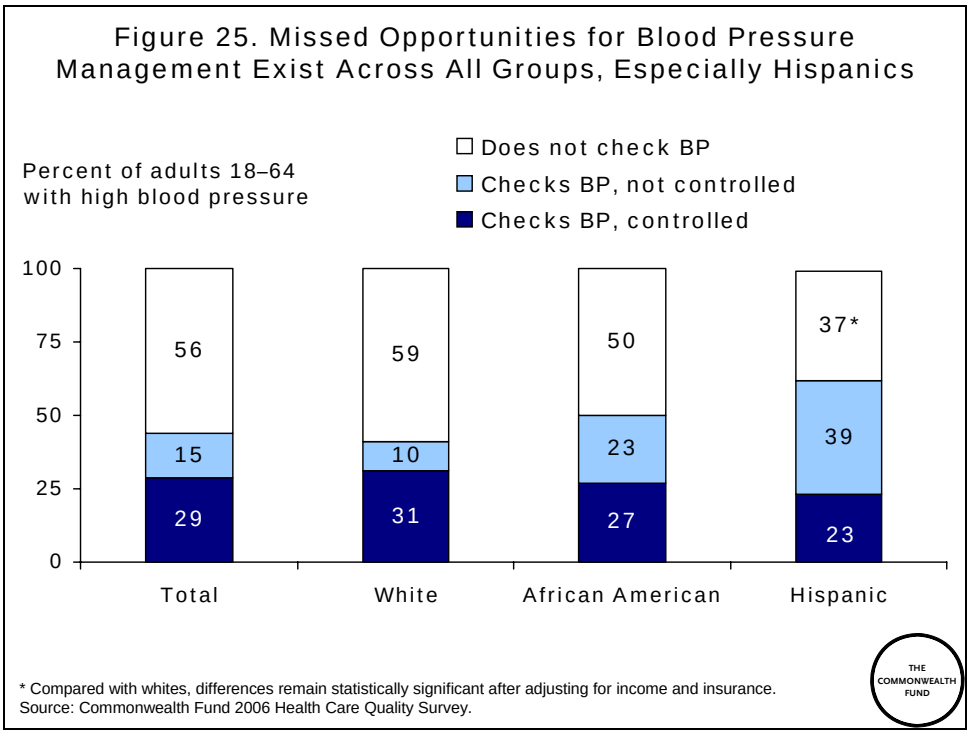
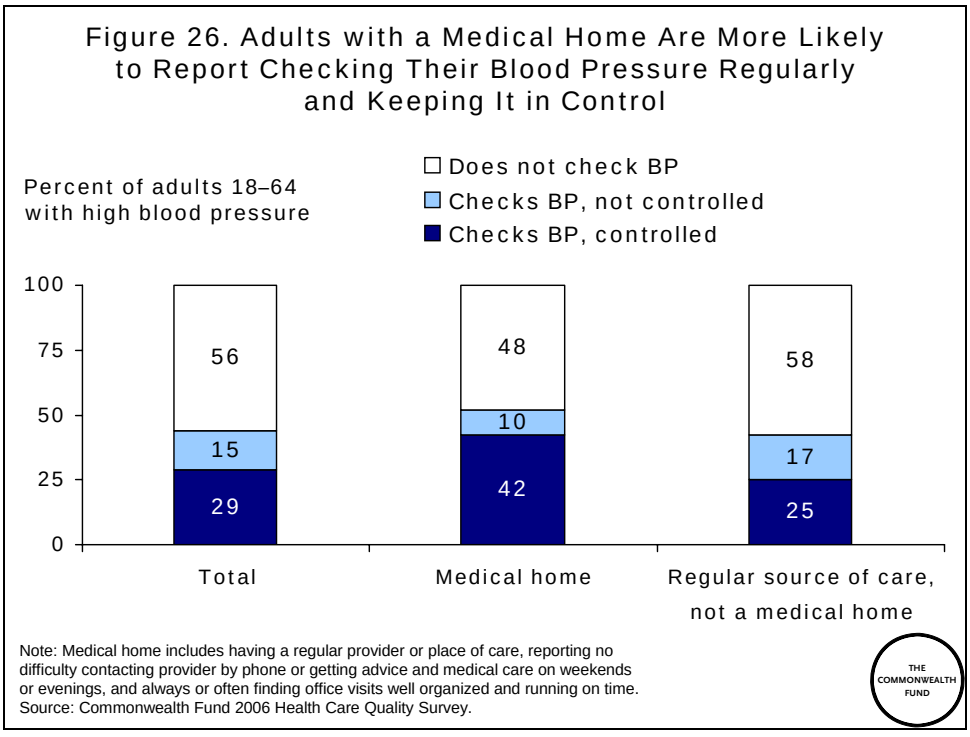
Adults in medical homes are more likely to have their conditions well managed and well controlled. High blood pressure is the most common chronic condition among adults. It is a good example of a condition that requires patients to monitor themselves and make lifestyle changes, including changes to their diet and exercise. Survey results indicate that high blood pressure is generally poorly managed and controlled among all adults, but especially among Hispanics. As a first step in self-management, patients should monitor their blood pressure on a regular basis. The survey finds that over half of hypertensive adults do not do so regularly, with 59 percent of whites, 50 percent of African Americans, and 37 percent of Hispanics reporting they do not regularly check their blood pressure (Figure 25). Forty-four percent check regularly—but less than one of three adults with high blood pressure has it in control (defined as a systolic pressure <140 mm Hg and a diastolic pressure <90 mm Hg). Only 23 percent of Hispanics reported that their blood pressure is in control, compared with 27 percent of African Americans and 31 percent of whites.

The survey also indicates that the best clinical results for hypertension are achieved among those with medical homes. More than half of hypertensive adults with a medical home reported checking their blood pressure on a regular basis, compared with 42 percent of hypertensive adults with a regular provider but not a medical home. Furthermore, hypertensive adults with a medical home are substantially more likely to have their blood pressure under control: 42 of hypertensive adults with a medical home reported they check their blood pressure regularly and it is in control, compared with only 25 percent of those with a regular provider but not a medical home (Figure 26). Overall, the survey finds significant room for improvement in management of chronic conditions among all adults. However, the results demonstrate that those who have medical homes have the best opportunities to manage their chronic conditions and achieve optimal outcomes.



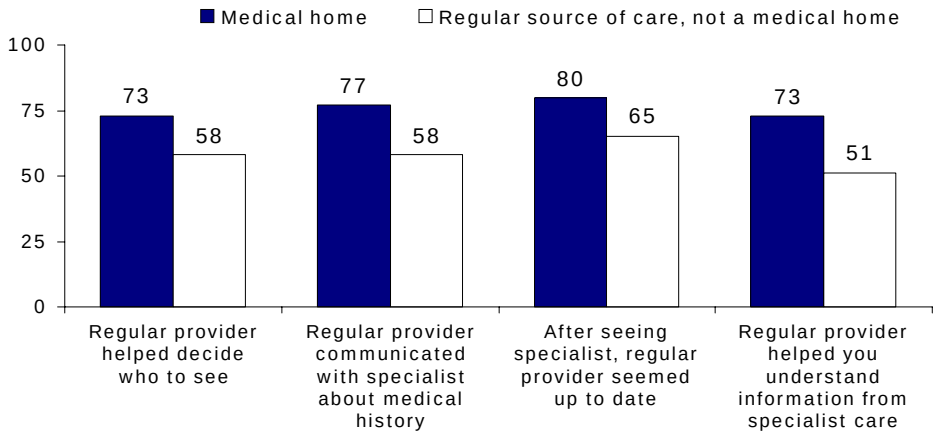


Patients with medical homes have better coordination of care with specialists. In a medical home, care should be effectively coordinated across different domains of the health care system and between providers.[10] Continuity and coordination

of care can reduce duplicative services and improve care for all patients, particularly those who have several different medical conditions or require care from multiple providers.

The survey asked respondents whether they had seen a specialist and whether their regular provider helped them coordinate specialty care. Specifically, respondents were asked whether their providers: 1) helped them decide which specialist to see, 2) communicated with the specialist about their medical history, 3) seemed up-to-date about the results from the specialist, and 4) helped them understand the information or care they received from the specialist. There were no racial differences on any of these measures of care coordination (Table 3). Yet, adults with medical homes—no matter their race—reported greater care coordination than those with a regular provider but no medical home. Three-fourths or more of adults with a medical home reported that their providers helped them decide which specialist to see, communicated with the specialist about their medical history, seemed up-to-date about the results from the specialist, and helped them understand the information or care they received from the specialist. Among adults with a regular provider but not a medical home, coordination between provider and specialists was not as strong (Figure 27).

Figure 27. Patients with a Medical Home Report Better Coordination Between Their Regular Provider and Specialist



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Source: Commonwealth Fund 2006 Health Care Quality Survey.

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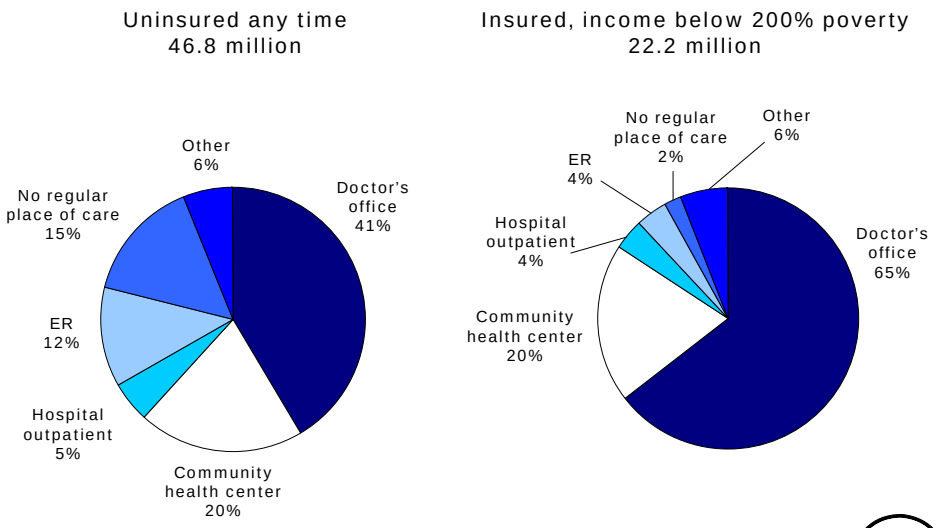
SAFETY NET PROVIDERS

Community health centers and other public clinics play an important role in providing care for uninsured and low-income populations. Safety net institutions, such as public hospitals and community health centers, play a critical role in ensuring access to care, since they accept all patients regardless of their ability to pay. The survey found that community health centers and other public clinics provide care to 20 percent of the 46.8 million uninsured U.S. adults identified by the Commonwealth Fund survey. In addition, community health centers and other public clinics care for 20 percent of low-income adults who have health insurance (Figure 28). Physicians in private practice are the main source of care for both uninsured and low-income insured populations. Yet, a larger proportion of minority than white adults name community health centers or public clinics as their regular source of care. More than one of five Hispanics and 13 percent of African Americans use community health centers or public clinics as their regular place of care, compared with only 9 percent of whites and 7 percent of Asian Americans (Figure 29).

Although community health centers and other public clinics play an important role in providing health care to vulnerable patient populations, they are less likely than private doctors' offices to provide medical homes, as defined by the four indicators in the survey. Results show that 21 percent of adults who visit community health centers or public clinics as their usual source of care reported that their source of care provides all four indicators of a medical home, compared with 32 percent of adults who rely on private doctors' offices. For example, adults who use community health centers or public clinics were less likely than those who use private physician practices to report no difficulty contacting their provider by phone, but there are no such differences between community health centers or public clinics and other sources of care, including hospital outpatient departments (Figure 30). The survey also found that the systems for improving the quality of care provided in community health centers and other public clinics can be improved. For example, preventive care reminders and cholesterol screening are more common in doctors' offices than in community health centers or public clinics (Figure 31).

Figure 28. Community Health Centers Serve Large Numbers of Uninsured Adults and Insured Adults with Low Incomes



Note: Percentages may not sum to 100% because of rounding.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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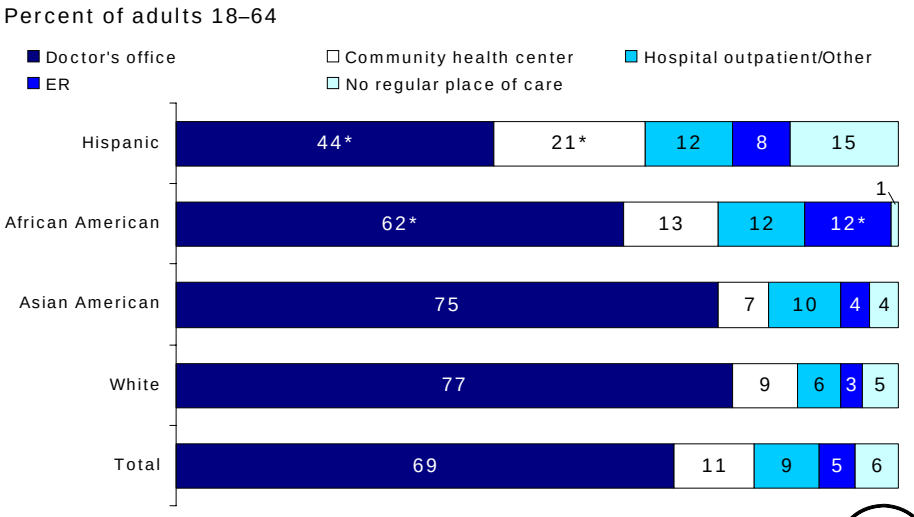
Figure 29. Hispanics and African Americans Are More Likely to Rely on Community Health Centers as Their Regular Place of Care



* Compared with whites, differences remain statistically significant after adjusting for insurance or income.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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Figure 30. Indicators of a Medical Home by Usual Health Care Setting
(adults 18–64)

Indicator	Total	Usual Health Care Setting: Doctors' office	Usual Health Care Setting: Community health center or public clinic	Usual Health Care Setting: Other settings*
Regular doctor or source of care	80%	95%	78%	63%
Among those with a regular doctor or source of care . . .				
Not difficult to contact provider over telephone	85	87	77	77
Not difficult to get care or medical advice after hours	65	67	54	69
Always or often find visits to doctors' office well organized and running on time	66	68	56	60
All four indicators of a medical home	27	32	21	22

* Includes hospital outpatient departments and other settings.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

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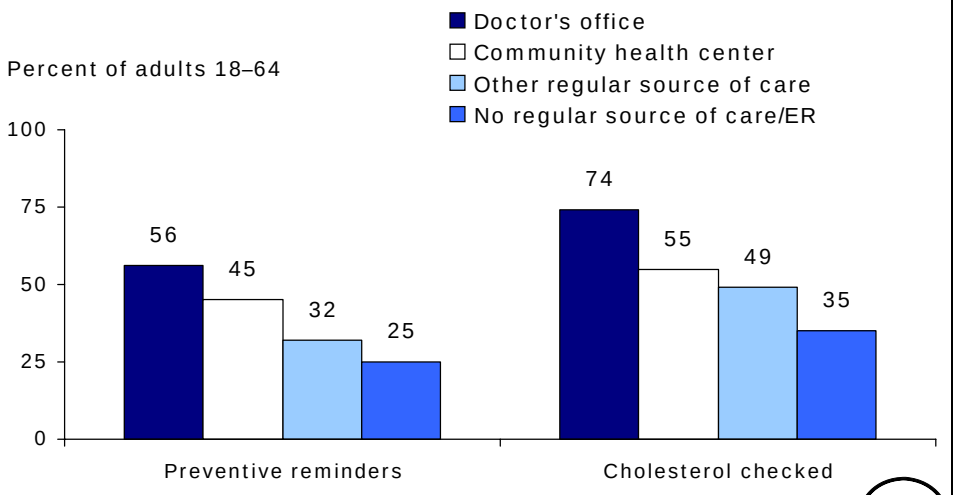
Figure 31. Preventive Care Reminders and Cholesterol Screening Are More Common in Doctors' Offices, But Community Health Centers Are Not Far Behind



Source: Commonwealth Fund 2006 Health Care Quality Survey.

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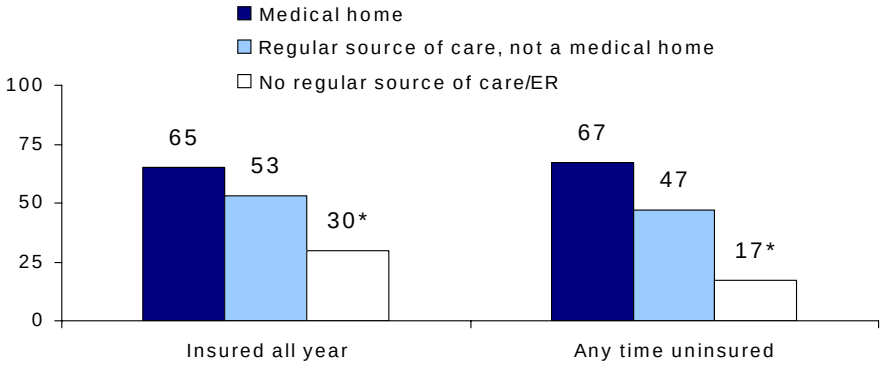
Access to a medical home improves quality and reduces disparities for the uninsured. Safety net providers that function as medical homes not only ensure access to needed care but also provide high-quality care. Compared with insured adults at all income levels, the uninsured are less likely to have a medical home (Figure 9). Yet, for uninsured patients that have access to a medical home through a high-quality safety net provider, disparities in some aspects of care can be ameliorated or even eliminated.

For example, having a medical home eliminates disparities in terms of the receipt of preventive care reminders between the insured and uninsured. Two-thirds of both insured and uninsured adults in medical homes receive reminders, compared with half of adults, both insured and uninsured, with regular providers that are not medical homes (Figure 32).

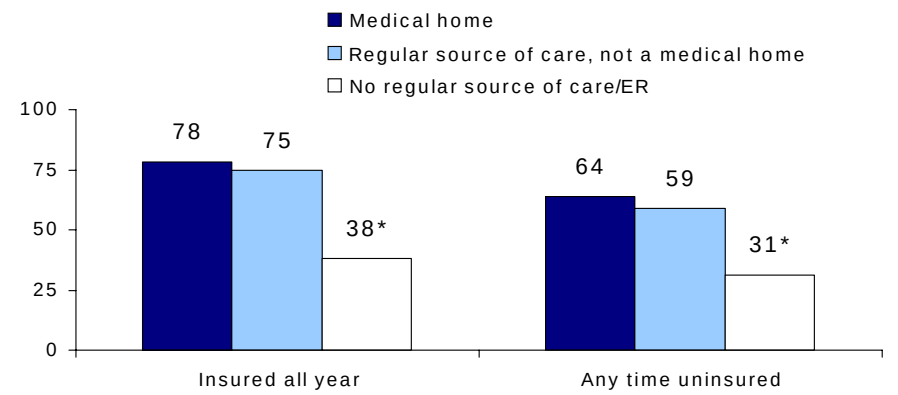
Regarding cholesterol screening, the rates are higher among insured adults with medical homes than those without such homes. Similarly, screening rates are higher among uninsured adults with medical homes than those without medical homes. However, disparities by insurance status are not eliminated. Among those with a medical home, 78 percent of insured adults receive cholesterol screening, compared with 64 percent of the uninsured (Figure 33).

Figure 32. Patients with Medical Homes—Whether Insured or Uninsured—Are Most Likely to Receive Preventive Care Reminders



Note: Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.
* Compared with medical home, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

Figure 33. Even When Uninsured, Adults with a Medical Home Have Higher Rates of Cholesterol Screening



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* Compared with medical home, differences are statistically significant.
Source: Commonwealth Fund 2006 Health Care Quality Survey.

THE COMMONWEALTH FUND

CONCLUSIONS

Racial and ethnic disparities in health care have been documented for years. Evidence suggests that such disparities are not immutable, but instead can be addressed through targeted policies and practices. The Commonwealth Fund 2006 Health Care Quality Survey found that, when adults have insurance coverage and a medical home, racial and ethnic disparities in access and quality are reduced or eliminated.

Other studies have shown that access to primary care can reduce disparities.[11] But beyond basic primary care, this survey found that access to high-performing primary care *delivered in a medical home* may improve outcomes for vulnerable patient populations. Indeed, the vast majority of adults with a medical home reported that they always get the care they need, when they need it. Moreover, racial and ethnic differences in getting needed care disappear among those who have a medical home, while differences in preventive care and management of chronic conditions are either reduced or eliminated among those with a medical home.

The use of patient reminders also improves the quality of care of vulnerable patients. The survey found that rates of cholesterol, breast cancer, and prostate screening are higher among adults who receive patient reminders, and that when minority patients have medical homes, they are just as likely as whites to receive these reminders.

Overall, when health care settings provide medical homes, the disparities and poor outcomes experienced by minority, low-income, or uninsured adults can be reduced or eliminated. However, community health centers and other public clinics—which care for a significant proportion of uninsured and low-income adults—are less likely than private doctors' offices to provide medical homes. Policies that specifically promote access to a medical home for vulnerable patient populations could help reduce or even eliminate health care disparities experienced by minority, low-income, or uninsured adults. Such polices include:

- ensuring stable health insurance coverage for all;
- publicly reporting which providers meet the standards of a medical home;
- recognizing and rewarding high-performing medical homes;
- working with physicians, community health centers and other public clinics, hospital outpatient departments, and other primary care providers to promote features of a medical home, including access to a regular provider, after-hours care, and coordination of health care services;
- working with primary care providers to promote use of preventive care reminders, encourage chronic disease self-management plans, and encourage counseling on diet and exercise; and
- campaigning to transform all primary care providers, including safety net providers, into medical homes.

Few providers or health care systems can say with certainty that there are no disparities in the quality of care delivered to their patients. However, the medical home holds extraordinary promise as a model for delivering high-quality care and eliminating disparities experienced by racial and ethnic minorities and uninsured patients. Replication of this model, particularly among safety net providers, could potentially improve the quality of care delivered to all patients while reducing disparities in care experienced by vulnerable patient populations.

NOTES

[1] N. Lurie and T. Dubowitz, "Health Disparities and Access to Health," *Journal of the American Medical Association,* Mar. 14, 2007 297(10):1118–21.

[2] M. M. Doty and A. L. Holmgren, *Health Care Disconnect: Gaps in Coverage and Care for Minority Adults* (New York: The Commonwealth Fund, Aug. 2006); M. M. Doty and A. L. Holmgren, *Unequal Access: Insurance Instability Among Low-Income Workers and Minorities* (New York: The Commonwealth Fund, Apr. 2004).

[3] Doty and Holmgren, *Health Care Disconnect,* 2006.

[4] M. Regenstein, J. Huang, L. Cummings et al., *Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems* (New York: The Commonwealth Fund, June 2005); L. S. Hicks, J. Z. Ayanian, E. J. Orav et al., "Is Hospital Service Associated with Racial and Ethnic Disparities in Experiences with Hospital Care?" *American Journal of Medicine,* May 2005 118(5):529–35.

[5] American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee, "The Medical Home," *Pediatrics,* July 2002 110(1 Pt. 1):184–86.

[6] S. C. Schoenbaum and M. K. Abrams, *No Place Like Home* (New York: The Commonwealth Fund, Dec. 2006).

[7] In February 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association developed principles to describe the characteristics of a patient-centered medical home. American Academy of Family Physicians et al., "Joint Principles of the Patient-Centered Medical Home" (Feb. 2007). Available at http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.tmp/022107medicalhome.pdf.

[8] Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (Washington, D.C.: National Academies Press, May 2002).

[9] J. H. Wasson, D. J. Johnson, R. Benjamin et al., "Patients Report Positive Impacts of Collaborative Care," *Journal of Ambulatory Care Management,* July–Sept. 2006 29(3 Special Issue).

[10] American Academy of Family Physicians et al., "Joint Principles," 2007.

[11] L. Shi, B. Starfield, R. Politzer et al., "Primary Care, Self-Rated Health, and Reductions in Social Disparities in Health," *Health Services Research,* June 2002 37(3):529–50.

APPENDIX A. DATA TABLES

Table 1. Access to a Medical Home by Race/Ethnicity & Insurance and Poverty Status
Base: Adults 18–64

	Race/Ethnicity					Insurance and Poverty Status*		
						Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Unweighted N	2837	650	757	892	455	1314	422	817
Estimated number of adults (in thousands)	177.3	114.6	20.2	24.9	8.3	89.5	22.2	46.8
Weighted percentages	100%	65%	11%	14%	5%	50%	13%	26%
Usual place of care								
Doctor's office or private clinic	69	77	62	44	75	85	65	41
Community health center or public clinic	11	9	13	21	7	6	20	20
ER	5	3	12	8	4	2	4	12
No regular place of care	6	5	1	15	4	1	2	15
Hospital outpatient	4	2	9	5	7	3	4	5
Other/Don't know/Refused	5	5	3	7	3	3	6	6
Has regular doctor	73	79	72	49	77	85	82	45
No regular source of care (includes ER, no regular place of care, and no regular provider)	20	15	21	43	16	9	12	45
Availability of regular provider by phone, and after hours								
Ability to contact your provider over the telephone about a health problem								
Very difficult	6	6	7	9	4	4	12	10
Somewhat difficult	9	7	12	15	12	8	11	9
Not too/Not at all difficult	81	83	80	70	80	83	75	76
Ability to get care or the medical advice you need in the evenings or weekends								
Very difficult	16	15	17	20	17	12	21	26
Somewhat difficult	18	19	15	19	17	20	20	17
Not too/Not at all difficult	47	45	57	42	48	47	51	44
Don't know/Refused	19	21	11	19	18	21	9	13
Very or somewhat difficult to do either of the above	39	38	36	47	38	36	45	49

	Race/Ethnicity					Insurance and Poverty Status*		
						Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Rating of office visits								
How often do you find the visits well organized and running on time?								
Always	31	30	34	34	30	29	39	31
Often	34	38	30	25	31	38	25	30
Sometimes	20	18	23	26	25	20	22	21
Rarely or never	13	13	12	13	11	12	14	16
Indicators of medical home[a]								
Medical home	27	28	34	15	26	30	34	16
Regular source of care, not a medical home	54	58	45	42	59	61	54	39
No regular source of care/ER	20	15	21	43	16	9	12	45
Communication by email								
Emails doctor now	22	21	31	21	17	24	19	21
Does not email doctor, but would like to	16	15	13	23	23	17	17	18
Does not email and does not want to	24	22	26	27	31	22	23	28
No access to computer	10	10	13	12	6	5	25	13
Don't know/Refused	28	32	16	18	23	32	15	20

* Note: Respondents in the unknown or "mixed" race category are not shown; respondents who are insured with unknown poverty status are not shown.

[a] Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone, or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006Health Care Quality Survey.

Table 2. Access, Preventive Care, and Physician Counseling
by Race/Ethnicity, Indicators of a Medical Home, Insurance and Poverty Status
Base: Adults 18–64

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Unweighted N	2837	650	757	892	455	771	1440	626	1314	422	817
Estimated number of adults (in thousands)	177.3	114.6	20.2	25.0	8.3	47.3	94.9	35.1	89.5	22.2	46.8
Weighted percentages	100%	65%	11%	14%	5%	27%	54%	20%	50%	13%	26%
Timely access to care											
When you think about your health care in general, how often do you receive the health care YOU need WHEN you need it?											
Always	55	57	56	46	48	74	52	38	61	61	36
Often	23	24	21	16	24	19	28	15	26	18	20
Sometimes	13	11	16	17	16	4	15	19	9	15	22
Rarely or never	7	6	6	14	8	1	5	22	3	6	17
When in need of medical attention, how soon are you able to get an appointment?											
Same day or next day	63	66	59	55	54	76	62	43	67	61	53
2 to 3 days	14	14	15	9	20	11	16	10	16	10	13
4 to 5 days	4	4	5	5	3	3	4	3	4	3	6
6 days or longer (includes more than a week, never able to get an appointment, went to ER/UCC)	17	14	19	26	18	8	15	38	12	24	25

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Preventive care											
Doctor's office reminded you to schedule preventive care	49	53	49	39	37	65	52	22	55	58	36
Cholesterol checked in past five years	66	67	63	56	62	76	72	34	73	65	47
Received mammogram in past two years (women ages 40–64)	73	73	77	76	78	79	74	49	80	76	44
Received blood test or rectal exam for prostate cancer in past two years (men ages 40–64)	52	54	57	39	54	77	47	34	55	64	35
Physician counseling in past two years											
Doctor discussed about the health risks of smoking and ways to quit (among smokers)	72	74	73	52	62	84	82	42	77	87	59
Doctor discussed exercise and having a healthy diet and weight	60	61	65	54	57	70	66	31	65	67	46
Doctor discussed any emotional concerns you may be affect your health	26	27	26	25	16	28	28	18	24	43	26

* Note: Respondents in the unknown or "mixed" race category are not shown; respondents who are insured with unknown poverty status are not shown.

[a] Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone, or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Table 3. Chronic Disease Management and Coordination of Care
by Race/Ethnicity, Indicators of a Medical Home, Insurance and Poverty Status
Base: Adults 18–64

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Adult with a chronic disease (Unweighted N=)	**934**	**246**	**348**	**211**	**100**	**297**	**512**	**125**	**437**	**185**	**221**
Chronic disease management											
Was not given plan to manage condition at home	35%	31%	36%	48%	54%	23%	35%	65%	27%	30%	56%
How confident are you that you can control or manage your health problems?											
Very confident	68	72	63	57	62	75	65	65	73	66	66
Somewhat confident	23	21	28	24	25	20	24	19	21	24	20
Not too/Not at all confident	5	3	7	15	10	2	6	13	3	8	8
Adults with high blood pressure or heart disease (Unweighted N=)	**511**	**139**	**201**	**103**	**56**	**153**	**290**	**68**	**257**	**87**	**119**
Management of high blood pressure											
Does not check blood pressure regularly	56%	59%	50%	37%	—	48%	58%	—	51%	56%	65%
Checks blood pressure regularly, BP not in control**	15	10	23	39	—	10	17	—	16	16	16
Checks blood pressure regularly, BP is controlled	29	31	27	23	—	42	25	—	33	28	19
Was not given plan to manage condition at home	34	30	34	54	—	24	33	—	27	37	50
Not too/Not at all confident can control or manage health problem	6	3	8	19	—	2	5	—	2	10	11

	Race/Ethnicity					Indicators of a Medical Home[a]			Insurance and Poverty Status*		
						Regular source of care		No regular source of care/ER	Insured all year		Any time uninsured
	Total	White	African American	Hispanic	Asian American	Medical home	Not a medical home	No regular source of care/ER	Income at or above 200% poverty	Income below 200% poverty	Any time uninsured
Adults who have seen specialist in last two years (Unweighted N=)	**1075**	**328**	**312**	**221**	**171**	**342**	**699**	**34**	**641**	**175**	**163**
Coordination of care between specialist and regular doctor											
Regular provider helped decide who to see	62%	61%	62%	62%	74%	73%	58%	—	60%	77%	60%
Regular provider communicated with him/her about medical care or history	63	62	69	65	54	77	58	—	60	82	62
Saw a specialist and regular provider seemed informed and up-to-date	70	68	72	73	69	80	65	—	66	87	70
Regular provider helped you understand about care received from specialist	57	54	62	65	55	73	51	—	54	73	59

* Note: Respondents in the unknown or "mixed" race category are not shown; respondents who are insured with unknown poverty status are not shown.

** Controlled blood pressure is diastolic under 90 and systolic is under 140.

[a] Medical home includes having a regular provider or place of care, reporting no difficulty contacting provider by phone, or getting advice and medical care on weekends or evenings, and always or often finding office visits well organized and running on time.

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Table 4. Health Status by Race/Ethnicity and Insurance Status
Base: Adults 18–64

		Race/Ethnicity				Insurance Status	
	Total	**White**	**African American**	**Hispanic**	**Asian American**	**Insured all year**	**Any time uninsured**
Unweighted N	2837	650	757	892	455	2020	817
Estimated number of adults (in thousands)	177.3	114.6	20.2	24.9	8.3	130.5	46.8
Weighted percentages	—	65%	11%	14%	5%	74%	26%
Self-rated health status							
Excellent or very good	55	62	44	31	52	59	43
Good	30	26	39	38	38	28	37
Fair/Poor	15	11	17	29	10	13	20
Current health conditions							
Diabetes or sugar diabetes	7	6	10	8	6	8	5
High blood pressure	21	21	29	15	14	22	16
Asthma, bronchitis, emphysema, or other lung conditions	13	14	16	10	6	12	17
Heart disease, heart failure or heart attack	5	6	6	4	3	6	3
At least one chronic condition	34	35	43	24	22	35	31
Disability or handicap limits daily activities	14	14	15	14	8	15	14
Any chronic or any disability	39	40	48	29	25	40	37
Obesity and overweight							
Underweight or normal weight	37	41	26	25	65	39	32
Overweight	31	32	32	28	24	33	25
Obese	24	22	37	21	5	22	30
Don’t know/Refused	7	4	5	26	6	5	13

Source: Commonwealth Fund 2006 Health Care Quality Survey.

Table 5. Sociodemographic Characteristics by Race/Ethnicity
Base: Adults 18–64

	Total	White	African American	Hispanic	Asian American
Unweighted N*	2837	650	757	892	455
Estimated number of adults (in thousands)	177.3	114.6	20.2	24.9	8.3
Weighted percentages	—	65%	11%	14%	5%
Age					
18–29	24	22	28	33	27
30–49	48	44	48	51	54
50–64	28	33	24	16	19
Education					
Less than high school	13	7	15	41	6
High school diploma or equivalent	35	36	41	30	22
Some college/Technical	24	25	25	18	20
College graduate or higher	28	32	18	11	51
Annual income					
Less than $20,000	16	12	32	23	10
$20,000–$39,999	19	17	24	25	15
$40,000–$59,999	16	18	15	13	15
$60,000+	34	40	20	13	41
Don’t know/Refused	15	13	9	25	18
Poverty status					
Under 100% poverty	10	6	23	18	9
100%–199% poverty	14	13	19	20	9
Under 200% poverty	24	18	42	39	17
200% poverty or more	61	69	49	36	64
Don’t know/Refused	15	13	9	25	18
Work status					
Full-time	60	62	59	53	62
Part-time	11	11	9	14	14
Not currently working	28	26	31	32	24
Family work status					
At least 1 full-time worker	47	51	35	42	59
Only part-time workers	35	33	38	40	27
No worker in family	18	16	26	17	13
Nativity status					
Born in U.S.	83	96	92	38	24
Foreign born, living in U.S. less than 5 years	3	1	2	14	6
Foreign born, living in U.S. less 5–10 years	3	1	1	12	11
Foreign born, living in U.S. more than 10 years	11	3	4	35	58
Type of insurance coverage at time of survey					
Employer	63	68	54	43	71
Individual/Other	8	10	6	6	12
Public (Medicaid/Medicare)	12	9	23	16	7
Uninsured	17	13	17	35	10

	Total	White	African American	Hispanic	Asian American
Stability of insurance throughout year					
Insured all year	74	79	72	51	81
Insured now, time uninsured in past year	9	8	11	14	8
Uninsured now	17	13	17	35	10
Any time uninsured in past year	26	21	28	49	18
Insurance and poverty status					
Below 200% of poverty					
Insured all year	51	55	54	42	54
Uninsured now, time uninsured in past year	17	14	18	19	18
Uninsured now	32	31	28	39	28
At or above 200% of poverty					
Insured all year	83	84	85	69	90
Uninsured now, time uninsured in past year	6	6	6	12	5
Uninsured now	11	10	9	20	5

* Note: Other and “mixed” race/ethnicity category not shown.

Source: Commonwealth Fund 2006 Health Care Quality Survey.

APPENDIX B. SURVEY METHODOLOGY

The Commonwealth Fund 2006 Health Care Quality Survey was conducted by Princeton Survey Research Associates International from May 30 through October 19, 2006. The survey consisted of 25-minute telephone interviews, conducted in either English or Spanish, among a random, nationally representative sample of 3,535 adults age 18 and older living in the continental United States. This report restricts the analysis to the 2,837 respondents ages 18 to 64.

The sample was designed to target African American, Hispanic, and Asian American households. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 18 and older living in the continental United States. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, marital status, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 177.3 million adults ages 18 to 64.

This study groups respondents by four race/ethnic groups, including non-Hispanic white, non-Hispanic African American, Hispanic, and non-Hispanic Asian American. The study also classifies adults by insurance status and annual income. Adults reporting they were uninsured when surveyed or were uninsured during the past 12 months were classified as uninsured any time during the year. Adults who were insured all year were further classified into two groups by their poverty status: insured all year with income below 200 percent of the federal poverty level, or insured all year with income at or above 200 percent of poverty. Ten percent of adults ages 18 to 64 who were insured all year did not provide sufficient income data for classification.

The survey has an overall margin of sampling error of +/– 2.9 percentage points at the 95 percent confidence level. The 50 percent response rate was calculated consistent with standards of the American Association for Public Opinion Research.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

Disparities in Health Care Are Driven by Where Minority Patients Seek Care (June 25, 2007). Romana Hasnain-Wynia, David W. Baker, David Nerenz, Joe Feinglass, Anne C. Beal, Beth Landrum, Raj Behal, and Joel S. Weissman. *Archives of Internal Medicine,* vol. 167, no. 12.

Improving the Management of Chronic Disease at Community Health Centers (March 1, 2007). Bruce E. Landon, LeRoi S. Hicks, A. James O'Malley, Tracy A. Lieu, Thomas Keegan, Barbara J. McNeil, and Edward Guadagnoli. *New England Journal of Medicine,* vol. 356, no. 9.

Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care (January 2007). Bruce Siegel, Marsha Regenstein, and Karen Jones.

No Place Like Home (December 2006). Stephen C. Schoenbaum and Melinda K. Abrams.

Patients Report Positive Impacts of Collaborative Care (July–September 2006). John H. Wasson, Deborah J. Johnson, Regina Benjamin, Jill Phillips, and Todd A. MacKenzie. *Journal of Ambulatory Care Management,* vol. 29, no. 3.

Health Care Disconnect: Gaps in Coverage and Care for Minority Adults (August 2006). Michelle M. Doty and Alyssa L. Holmgren.

Comparative Perspectives on Health Disparities (February 2006). Vanessa Northington Gamble, Deborah Stone, Kala Ladenheim, Brian K. Gibbs et al. *Journal of Health Politics, Policy and Law,* vol. 31, no. 1.

Caring for Patients with Diabetes in Safety Net Hospitals and Health Systems (June 2005). Marsha Regenstein, Jennifer Huang, Linda Cummings, Daniel Lessler, Brendan Reilly, and Dean Schillinger.

Is Hospital Service Associated with Racial and Ethnic Disparities in Experiences with Hospital Care? (May 2005). LeRoi S. Hicks, John Z. Ayanian, E. John Orav, Jane Soukup, Michael McWilliams, Sharon S. Choi, and Paula A. Johnson. *American Journal of Medicine,* vol. 118, no. 5.

Unequal Access: Insurance Instability Among Low-Income Workers and Minorities (April 2004). Michelle M. Doty and Alyssa L. Holmgren.

Joint Meeting of Oregon Health Fund Board and Delivery System Committee
December 12, 2007
Speaker Bios

David Dorr
David Dorr, MD, is assistant professor of medical informatics and clinical epidemiology at the Oregon Health & Science University School of Medicine. Dr. Dorr earned his BA in Economics and his MD from Washington University in St. Louis. He then completed an Internal Medicine residency at Oregon Health & Science University, and earned a Master's in Medical Informatics and Health Services Administration from the University of Utah. His current projects include Expanding Guidelines to Collaborative Care Management and he is the principal investigator for the Care Management Plus project. He also works with RADAR (research on Adverse Drug Events and Reports) and the Internal Review Board to improve patient safety. Additionally, his work on collaborative systems has led him to align with the Creating HealtheVet Informatics Applications for Collaborative Care (CHIACC) Group.

Thomas Hickey
Thomas Hickey, MD, is clinical director of population care for the Kaiser Northwest region. He is a family physician and practices at the Kaiser Clinic in Longview, WA. Dr. Hickey earned his BS in Biology from the University of California-Irvine, his MS in Pharmacognosy and Pharmacology from the University of Illinois and his MD from Rush Medical School in Chicago. He is board certified by the American Board of Family Medicine.

Chuck Kilo
Chuck Kilo, MD, is the CEO of GreenField Health, a network of medical practices and a teaching and consulting company serving those interested in health care quality and performance improvement. He is executive director of the newly formed non-for-profit Trust for Healthcare Excellence which promotes the collective efforts and conditions necessary for health and healthcare excellence. He is a fellow and senior faculty of the Institute for Healthcare Improvement (IHI) where he was previously vice president. At IHI, he developed and led the international Idealized Design of Clinical Office Practices initiative. This work sparked a national focus on medical practice performance improvement. Dr. Kilo works regularly with IHI, the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Board of Internal Medicine (ABIM), and others on issues pertinent to health care quality and performance improvement. He is on the Board of Directors of the Foundation for Medical Excellence, TransforMED (a subsidiary of the AAFP), the ACP's Center for Practice Innovation, and Kryptiq Corporation. Dr. Kilo speaks frequently on topics related to health care quality and safety, health system design, information technology, and performance improvement. He is a practicing internist with subspecialty training in infectious diseases. He attended Washington University School of Medicine where he also completed his internal medicine training. He subsequently completed an infectious diseases fellowship and Master of Public Health at Harvard University.

David Labby
David Labby, MD, PhD, is Medical Director of CareOregon, a Medicaid Health Plan serving 90,000 members under the Oregon Health Plan. He is a practicing general internist and Assistant Professor of Family Medicine at OHSU. He received his MD at Indiana State University and his PhD in Cultural Anthropology from the University of Chicago. Dr. Labby has been at CareOregon since 2000 and has focused on clinical quality and program development. He is the principal investigator for a grant from the Robert Wood Johnson Foundation (RWJF) on Depression in Primary Care and for a grant from the Center for Health Care Strategies on Making the Business Case for Quality focusing on case management of complex high-risk patients. He has also led programs on asthma and chronic pain management.

Ralph Prows
Ralph Prows, MD, is vice president and chief medical officer of Regence Blue Cross Blue Shield of Oregon. Dr. Prows joined Regence BCBSO in September 2004. He is responsible for the direction and coordination of health care services to all lines of business and products offered by Regence. He also directs the development and implementation of medical management activities for Oregon and has shared accountability for medical management functions in Washington, Idaho and Utah for The Regence Group. He also serves on the Board of Directors for the Oregon Health Care Quality Corporation and Oregon Health Policy Commission's Quality and Transparency Workgroup. Dr. Prows earned a medical degree from Tulane University School of Medicine and completed his residency in internal medicine at Oschner Foundation Hospital in New Orleans. He is board certified by the American Board of Internal Medicine and has current state medical licenses in Massachusetts and Oregon.

The Trust for Healthcare Excellence

"The Trust for Healthcare Excellence promotes the collective efforts and conditions necessary for health and healthcare excellence."

Summary
The Better Health Initiative, Boulder, CO, June 15-16, 2007
and
The Oregon Better Health Initiative, Portland, OR, July 26, 2007

> *"Destiny is not a matter of chance, it is a matter of choice;*
> *it is not a thing to be waited for, it is a thing to be achieved."*
> **William Jennings Bryant**
>
> *"The best way to predict the future is to invent it."*
> **Alan Kay, 1971**

These notes summarize the content and discussion at The Trust for Healthcare Excellence's Better Health Initiative meeting in Boulder, Colorado June 15-16 as well as the Oregon Better Health Initiative meeting July 26 in Portland.

Objective and Purpose

The objective of the Better Health Initiative is to foster a unified voice and grassroots action plan among advocates who believe in a systematic, evidence-based approach to health care reform. Because of its critical central purpose in high performing health systems, and because of it current weak position within the US health system, our initial focus is on primary care and its advocates.

The purpose of these meetings was to:

- Present a set of Guiding Principles for Healthcare
- Discuss the data that informs health system design
- Consider how primary care and its advocates can speak with a more unified voice and establish a plan for stronger, more cohesive primary care advocacy

To achieve the depth of change necessary in US healthcare, we believe that more significant progress is likely to be achieved by working at the state rather than national level. We believe that the direct engagement of front-line care providers in a positive process of and advocacy for deep system reform is important.

Definition of 'primary care'

"Primary Care" represents a team of healthcare professionals providing first contact longitudinal, integrated, relationship-based, "whole person" care for all aspects of health, both mental and physical – the 'medical home'.

While there are a variety of reactions to the term "primary care", it is the most recognized label for the functions that general pediatrics, internal medicine, and family medicine clinicians and teams provide. In discussing primary care, we assert that the primary care needed in the US is a team-based, multidisciplinary function supported by appropriate information technology and processes that allow it to provide comprehensive, longitudinal, coordinated, relationship-based care.

We acknowledge that existing primary care needs to evolve significantly to become this envisioned, comprehensive function. We also acknowledge that not all primary care is alike – that primary care design should be determined by the needs of the population served.

The Imperative

While the problems of quality of care are well known, the continually rising cost of healthcare represents an increasing threat to our communities. Healthcare spending is increasingly diverting funds away from other areas such as living wages for workers, public education, and other social services. In 2006 healthcare spending made up 17% of the US GDP and it is increasing approximately one percentage point every three years.

There are powerful economic currents that serve as challenges to healthcare reform: many individuals and institutions doing quite well economically within the current system, and we exist within a society that tends to value individualism (me) and individual good over the public (we) and public good. However, a focus on institutional/organizational finances and on individuals while ignoring the cost to society and the impact of not considering the public good is taking an increasing toll on our communities.

Former Oregon Governor Dr. John Kitzhaber offered three take home points:

1) We must control costs in order to avoid significant economic damage to our communities.
2) We cannot control costs by narrowly defining our current situation as an insurance problem, but rather we must rethink the "benefit" and delivery system design.
3) We are not powerless - there is a great deal we can accomplish working together.

The Process

It is essential to <u>define what we want healthcare to achieve</u> *before* we define what the system should look like. Once we define healthcare's purpose, we should use existing data to provide guidance on optimal health system design.

Both are possible today. We discussed the proposed Guiding Principles for Healthcare and the data that gives guidance to health system design:

Guiding Principles for Healthcare

1. **The objective (purpose) of our health system is health as measured at the individual, family, and community levels.** *This does not say that the purpose is 'access to health care', but rather the purpose is in fact 'health'. Health care is a means to health. We need to measure health at the individual, family, and community level. There can be a natural tension between a focus on individual/family health and community health - determining the right balance is critical.*

2. **Individual and community health are public assets. Universal access to basic health services is essential to the well-being of our workforce and our communities.** *As a public asset, it is economically advantageous (less expensive) to have a healthy public – employers benefit from having a healthier work-force and through less cost-shifting of healthcare dollars. We as individuals and our communities benefit by reducing the direct and indirect costs of poor health and disability. Given that we will always have limitations on healthcare spending, clearly defining the "basic health services" necessary to maintain a healthy public is crucial. The positive impact of public dollars can be maximized by directing them to those strategies that benefit everyone, both directly and indirectly.*

3. **Public resources should be allocated in a way that maximizes the health benefit across the population.** *Our focus is on public resources because we acknowledge that individuals can spend their own discretionary income to purchase additional health services. However, since health is a public asset, public resources should be allocated to maximize the asset, much like public education. This will require a social rebalancing of perspective on health care that re-includes community and public good in addition to individual good. It requires that we also begin assessing new healthcare technologies not just from the perspective of individual benefit, but from the perspective of public benefit. We have examples to build upon including public education and transportation systems.*

4. **Decision-making about the expenditure of public resources should be evidence-based and transparent.** *Public resources will be used to provide services that have proven effectiveness. While some will see this as rationing, since public resources for healthcare are and will always be limited, it is necessary to decide what is covered and what is not. How services are assessed and the decision making about the expenditure of resources will be transparent to the public. Not pursing this principle means that we retain and accept the current default – implicit rationing that favors some over others.*

5. **Health care services should be coordinated, integrated, and organized within the community to provide longitudinal care for comprehensive mental and physical health.** *We need to shift from our current episodic disease care system toward a more*

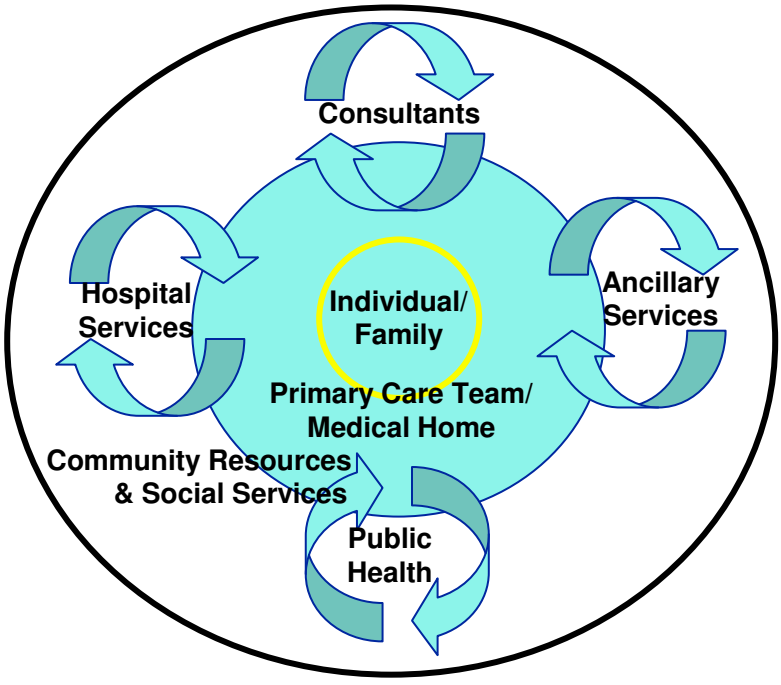
"wholistic" care system that increases focus on prevention and early detection and cares for people over time in the context of relationship through careful coordination and integration of care across providers. This principle provides the clearest guidance to health system design.

There was good discussion about the Guiding Principles and no critical disagreement. The employer community appears early on in their understanding of most of these principles – in particularly, they are early on in considering the objective to be health, and health as a public asset, although there is evidence that they are moving in that direction.

It is agreed that additional information is needed to explain these principles.

Health System Design

There is extensive, credible data both from within and outside of the US demonstrating that health care systems organized around well-designed primary care produce higher quality outcomes with lower costs. While we acknowledge that all models have limitations, the following is a valid high-level, evidence-based depiction of a health system design.



There was general acceptance of the data supporting health system design that puts patients/families at the core along with primary care teams. Salient aspects of this model include the presence of primary care teams in relationship with patients and families at the core of healthcare. Other resources are intentionally organized around this core to support patient care. We acknowledge that the primary care of today will need to change significantly if it is to fulfill its necessary role, but that others in healthcare must change their work as well so that the entire system and its resources are aimed at supporting coordinated, whole person, continuous care that respects the primary relationship

between primary care and its patients. As acknowledged in the Guiding Principles, the system is oriented not just to individuals, but toward optimizing health at the community level as well.

Data by Starfield and others was presented to support this model.

Public Health and Healthcare

If the objective of a health system is health as measured at the individual, family, and community levels, and if health is a public asset, then communities (nations, states, and local communities) must have well designed, effective public health and healthcare systems. We believe that both public health and healthcare require significant reform, and that the interaction between those entities requires a much great level of intentional design than currently exists. We value the importance of both the delivery system's and public health's role in achieving the Guiding Principles for Healthcare.

Due to the pressing economic imperative created by continual increases in healthcare spending, our initial focus is on healthcare and the delivery system rather than public health. We believe such a focus is necessary as a starting point. Plans are being made to incorporate public health (and others) into this work.

Focusing on Primary Care

In addition to establishing the principles and evidence-based system design, there was discussion about the current state of primary care. We acknowledge that the current financing environment exerts a strong influence on primary care's ability to provide necessary services, but, at the same time, we admitted that financing change alone is not the answer to the problems we face. We are supportive of current efforts to improve primary care funding which is being lead nationally by groups such as the AAFP, AAP, ACP, and AOA.

While financing changes are critical, we acknowledged that primary care – in its current form – will be challenged to fulfill its central role in healthcare. At both the medical group and local/community levels, we have serious concerns about the current state of primary care leadership, culture (beliefs, habits, behaviors), and organization in addition to its system design for chronic care management, prevention, and coordination and integration of care. While many efforts are focusing on assisting medical practices with performance improvement (i.e., implementation of the chronic care model, electronic health records), fewer national or local efforts have focused on improving primary care's leadership, culture, and organization.

Primary care (pediatrics, family medicine, and internal medicine) is heavily fragmented both in terms of its clinical organization (medical practices/medical groups) and its representation. While more unified primary care advocacy has begun to occur nationally, this has generally not been the case at the state and local levels where primary care has

frequently been without unified advocacy and a common voice. This situation has not served the cause of primary care or patients well.

For successful reform, the base of primary care needs to be engaged in a much more substantive manner in both leadership and action. The focus of the Better Health Initiative is on engaging primary care at local levels toward a new level of leadership, participation, cultural examination, and organization. To do so, we will also engage primary care advocates and advocates for evidence-based health system design. Driving such local change in leadership and advocacy will be the focus of our work and future meetings. We seek to create a convergent, consistent approach in order to mitigate the tendency within our industry toward the continual divergence of thinking and action that does not serve us well.

Next Steps

In summary, the next steps for the Better Health Initiative include:

1. Creation of the written Better Health Initiative Platform which will include a concise articulation of:
    a. Guiding Principles for Healthcare
    b. Evidence-based System Design

2. Action Plans to be tested at the state level to promote a new level of cohesive, grass roots advocacy to healthcare reform.

There was broad agreement that the approach outlined is a rational way of proceeding. We seek a platform for reform in which our collective advocacy – that of the many stakeholders who will be involved including primary care - goes beyond self interest.

What we hope to stimulate is a movement, in the best sense of the word engaging those at the front lines of care along with other advocates who share our vision of a better health care system. We seek to lead from the middle – calling leaders as well as front line health professionals to the vision and to the development and application of action plans.

Any movement requires consistent messaging and framing to succeed. A critical next step is to construct such a written platform that articulates our beliefs – a platform that serves as the foundation for our collective advocacy. This will be called the Better Health Initiative Platform, and particular attention will be paid to language and framing.

Next steps include:

1. Establish a writing group to articulate the Guiding Principles and evidence-based system design into a written Better Health Initiative Platform.
2. Set up a follow-up meeting in November to bring the group back together for additional work and planning
3. Initiate several state-level Better Health Initiatives to test methods of creating grass roots change in healthcare.

Next Steps for Oregon

Oregon will serve as an initial test state for promoting the Better Health Initiative. To this end, a group of local leaders have been meeting since March resulting in a meeting on July 26th as an initial step of stimulating statewide action. On July 26, approximately 100 individuals gathered for day to discuss these issues.

Follow-up steps will include the following:

1. Establish focused meetings of the following groups:
   - Primary care societies including the Oregon Academy of Family Physicians, Oregon Pediatric Society, Oregon Chapter of the ACP, and the Osteopathic Physicians and Surgeons of Oregon.
   - Residency directors for primary care specialties
   - Insurers
   - Purchasers
2. Schedule a second larger group meeting to debrief the focused meetings noted above and continue to plan and implement strategies for statewide primary care advocacy.

Unintended Consequences of Resource-Based Relative Value Scale Reimbursement

John D. Goodson, MD

MEDICINE'S GENERALIST BASE IS DISAPPEARING AS a consequence of the reimbursement system crafted to save it—the resource-based relative value scale.[1] The US physician workforce is unique among developed economies of the world. Virtually all European countries have a broad generalist foundation comprising 70% to 80% of practicing physicians. The United States is the opposite. Starfield[2] has summarized the benefits of a generalist workforce as access to health service for relatively deprived populations; care equal to specialists in most situations (recognizing the invaluable contribution of the specialist physicians but acknowledging that the diffusion of knowledge increases the ability of the nonspecialist to provide up-to-date care); improved preventive service delivery; efficient management of multiple simultaneous medical, surgical, and mental health problems in active and fully functional patients; provision of continuity in the health care experience, advice, and counsel where appropriate and access to appropriate diagnostic, consultative, and specialty services; and, in conjunction, reduced unnecessary specialty testing and consultation.

Over the last 4 decades, medical and surgical practice has transformed from a reactive profession to a proactive profession. Evidence from numerous clinical investigations in many different settings shows that patients with any of the 3 most common conditions—hypertension, diabetes, hypercholesterolemia—benefit from early treatment. Conversely, failure to diagnose and treat increases the likelihood of poor outcomes.

Well-designed studies have shown that the early and active treatment of disease in the asymptomatic phase has profound lifetime benefits. For instance, the Hypertension Detection and Follow-up Program[3] demonstrated the reduced mortality derived from the early identification and treatment of hypertension with benefits occurring in those managed closely with inexpensive therapies. The Diabetes Control and Complications Trial[4] showed that early and effective management of blood glucose levels for patients with type 1 diabetes reduced long-term risk for neuropathy, retinopathy, and nephropathy. The West of Scotland Study[5] showed that patients with coronary heart disease and risk factors had lower mortality if their low-density lipoprotein cholesterol levels were managed actively. Targets for secondary prevention decreased with successive clinical studies, and targets for primary prevention of heart disease followed suit.

The seventh Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) specifies that even the patient with normal blood pressure should be counseled about lifestyle modification to avoid later life development of high blood pressure.[6] The JNC 7 urges clinician empathy for a patient who generally feels well. The implication is that some physicians will convince a patient with a silent disease to change dietary and exercise habits and perhaps take daily medications.

The ever-expanding repertoire of interventions, screening tests, vaccines, and devices has dramatically increased the work of patient care for all physician specialties. As an indicator of this ever-expanding content, the total resource-based relative value units per Medicare beneficiary increased by 45% from 1992 to 2002.[7] For the generalist physician, this increase has been especially intense. Providing all recommended preventive services to a panel of 2500 patients could require up to 7½ hours a day of physician time.[8] Generalist physicians report that roughly 4 separate problems are addressed at each office visit for patients older than 65 years and even more issues are addressed for patients with chronic illnesses such as diabetes.[9] For a hypothetical 79-year-old woman with 5 medical conditions, current clinical practice guidelines would support the use of 12 medications.[10]

Attaining the expected health benefits from early and effective treatment of symptomatic and asymptomatic illness will not be achievable without increasing the number of generalists. The United States is now served by highly trained but limited-scope practitioners, at the very time skillful and well-supported primary care physicians are needed. The overall workload is overwhelming the capacity for generalist care if not the individual clinicians.

This problem will only be resolved with full recognition of its origins. Because physician decision making profoundly influences health care expenditures,[11] the forces that affect these decisions must be addressed. Practice type and physician specialty are critical factors; both are associated with higher rates of test ordering and hospitalization.[12] Gen-

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eralists with long, continuous clinical relationships with patients tend to generate lower health care costs for their patients.[13] Current reimbursement incentives substantially favor procedures and technical interventions and offer financial advantages for expensive care,[14] thereby encouraging specialty services. The Medicare experience illustrates the paradoxical health consequences of this economic pattern. States with higher Medicare spending have lower quality of care.[15] As a consequence of many economic forces, compensation for generalist physicians is roughly half or less than half the compensation for nearly all specialists.[16]

The Centers for Medicaid & Medicare Services (CMS) determines the relative payment rates for virtually all federally reimbursed professional services. The resource-based relative value scale[1] was intended to rationalize physician reimbursement and to reduce federal payment disparities among clinicians by assigning relative value units (RVUs) to all physician activities and expenses. Medicare reimbursement is determined for each service code by adding the work RVU, the practice expense RVU, and the liability RVU and multiplying each by separate payment units, or "conversion factors." All the RVU conversion factors are geographically adjusted. On average, the work RVU represents slightly more than half of the total; the practice expense RVU, slightly less than half; and the liability RVU, a small portion. The work RVU values issued by CMS have a profound effect on all professional reimbursement because most private indemnity insurance companies use the actual CMS RVU values or some derivative.

The American Medical Association (AMA) sponsors the resource-based relative value scale update committee (RUC) both as an exercise of "its First Amendment rights to petition the Federal Government" and for "monitoring economic trends . . . related to the CPT [Current Procedures and Terminology] development process."[17] Functionally, the RUC is the primary advisor to CMS for all work RVU decisions.

The RUC has 30 members (the chair only votes in case of a tie) with 23 of its members appointed by "national medical specialty societies."[17] Meetings are closed to outside observation except by invitation of the chair. Only 3 of the seats rotate on a 2-year basis. Other members have no term limits. Seventeen of the permanent seats on the RUC are assigned to a variety of AMA-recognized specialty societies including those that account for a very small portion of all professional Medicare billing, such as neurosurgery, plastic surgery, pathology, and otolaryngology. Proceedings are proprietary and therefore are not publicly available for review. Traditionally, more than 90% of the RUC's recommendations are accepted and enacted by CMS (http://www.ama-assn.org/ama1/pub/upload/mm/380/rvs_booklet_07.pdf). As the catalog of billing opportunities expands, the total number and, importantly, the type of RVUs delivered each year have increased. From 1992 to 2002, the number of evaluation and management services as measured by RVUs increased 18% while the number of nonmajor procedures increased 21%, and the number of imaging services increased 70%.[18] The resource-based relative value scale system "defies gravity"[19] with the upward movement of nearly all codes. In 2006, based on RUC recommendations, CMS increased RVUs for 227 services and decreased them for 26.[19]

Until 2007, CMS depended on historical survey data collected by the AMA and specialty societies that were heavily influenced by previous practice patterns and payment biases to determine practice expense. The 2007 Medicare Payment Advisory Commission[20] report outlined reimbursement "distortions" that emerged from this model through the overvaluations of practice expenses that incentivized certain procedures, the undervaluations that made certain professional work financially unattractive, and misevaluations that led to "unwise" expenditures by Medicare. Ginsburg and Berenson[19] calculated that failure of CMS to accurately adjust practice expense RVUs to reflect true equipment use and financing costs, acceptance of revised practice expense RVUs for 8 specialty societies, and congressionally mandated budget neutrality requirements reduced the January 1, 2007, increase in evaluation and management reimbursement from 20% to 6.5%.

The CMS intends to initiate a new method to more accurately calculate practice expenses, and there will likely be a modest shift in practice expense RVUs from procedures to evaluation and management services.[20] However, new distortions of practice expense may replace those of the past because the new practice expense RVUs are determined in part by work RVUs. The inaccuracies of one relative value system are carried into another. The enormous practice expenses related to the matching of medications to formularies required by Medicare Part D largely falls on the generalist practitioners, but the increased office expenses have yet to be included in the practice expense discussions.

The RUC has powerfully influenced CMS decision making and, as a result, is a powerful force in the US medical economy.[10] Furthermore, by creating and maintaining incentives for more and more specialty care and by failing to accurately and continuously assess the practice expense RVUs, the decisions of CMS have fueled health care inflation. Doing so has affected the competitiveness of US corporations in the global market by contributing to years of double-digit health care inflation that have consistently increased the costs of manufacturing and business in the United States over the last decades.

The continued and sustained incentives for medical graduates to choose higher-paying specialty careers and for those physicians in specialty careers to increase income through highly compensated professional activities have been associated with the dwindling of the generalist workforce. The lack of incentives for medical graduates to choose generalist careers in internal medicine, family medicine, and pediatrics has had a profound effect on the workforce mix and, ultimately, US health care expenditures.

Residents are choosing not to enter the generalist fields. For instance, among first-year internal medicine residents, less than

20% have interest in pursuing careers in general internal medicine.[21] Past trends indicate that only slightly more than half of these residents continue this commitment to general internal medicine to the completion of residency.[22] If this continues, as few as 10% of those training in internal medicine will to work as general internists.

Other factors contribute to the decline of the generalist workforce including the increase in administrative expectations from new quality improvement initiatives, record keeping inefficiencies, inadequately compensated disease management, and liability concerns.[23] As a result of the economic forces and the practice challenges, medical student and resident interest level will likely not sustain the generalist base beyond the next decade or so.

The generalist workforce crisis demands a system for reimbursement that reflects the dynamic and changing nature of medical practice. Physicians and payers have important roles. The relative value of clinical services should be determined by physicians, but they must accept federal oversight and accountability mandated by statute. The CMS should continually assess financial aspects of practice so expenses accurately reflect the true costs of changing clinical practice patterns and do not create undue incentives for overutilization or underutilization. The current mechanism fails to provide sufficient checks and balances and is skewed and dysfunctional.

The Medicare Payment Advisory Commission, a nonpartisan advisory panel to Congress, has identified the 4 dimensions of the professional services health care economy as physician reimbursement, workforce composition, expenditure management, and clinical effectiveness and quality.[24] Without a robust, well-supported, appropriately compensated, and self-sustaining generalist workforce, the majority of the US population will not be able to benefit from the powerfully effective interventions for the asymptomatic patients whose only contact with the health care system is through generalists. Furthermore, broad and affordable universal access to health care will not be possible without a solid base of generalists who can deliver care and organize appropriate referrals.[25]

The medical profession needs to reformulate the way the value of clinical services and the infrastructure expenses of practice are determined, needs to make the process open and accountable, and needs to solicit input and oversight from those who have the health of individuals, the nation, and the economy as their highest priorities. The resource-based relative value scale system originally developed to achieve full value for cognitive services currently threatens the sustainability of the generalist base. As a result, a large portion of the population will lose access to the continuous and personalized care provided by generalist physicians whose repertoire of clinical skills and interventions coupled with access to specialty and diagnostic services are essential for ensuring efficient and effective health care delivery.

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REFERENCES

1. Hsiao WC, Braun P, Yntema D, Becker ER. Estimating physicians' work for a resource-based relative-value scale. *N Engl J Med*. 1988;319(13):835-841.
2. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502.
3. Hypertension Detection and Follow-up Program Cooperative Group. Five-year findings of the hypertension detection and follow-up program, I: reduction in mortality of persons with high blood pressure, including mild hypertension. *JAMA*. 1979;242(23):2562-2571.
4. Writing Team for the Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications Research Group. Sustained effect of intensive treatment of type 1 diabetes mellitus on development and progression of diabetes nephropathy. *JAMA*. 2003;290(16):2159-2166.
5. Shepherd J, Cobbe SM, Ford I, et al; for the West Scotland Coronary Prevention Study Group. Prevention of coronary heart disease with pravastatin in men with hypercholesterolemia. *N Engl J Med*. 1995;333(20):1301-1307.
6. Chobanian AV, Bakris GL, Black HR, et al. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure: the JNC 7 report. *JAMA*. 2003;289(19):2560-2572.
7. Maxwell S, Zuckerman S, Berenson RA. Use of physicians' services under Medicare's resource-based payments. *N Engl J Med*. 2007;356(18):1853-1861.
8. Yarnall KS, Pollak KI, Østbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? *Am J Public Health*. 2003;93(4):635-641.
9. Beasley JW, Hankey TH, Erickson R, et al. How many problems do family physicians manage at each encounter? *Ann Fam Med*. 2004;2(5):405-410.
10. Boyd CM, Darer J, Coult C, et al. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases. *JAMA*. 2005;294(6):716-724.
11. Bodenheimer T, Fernandez A. High and rising health care costs, IV: can costs be controlled while preserving quality? *Ann Intern Med*. 2005;143(1):26-32.
12. Greenfield S, Nelson EC, Zubkoff M, et al. Variations in resource utilization among medical specialties and systems of care: results from the medical outcomes study. *JAMA*. 1992;267(12):1624-1630.
13. Weiss LJ, Blustein J. Faithful patients: the effect of long-term physician-patient relationships on the costs and use of health care by older Americans. *Am J Public Health*. 1996;86(12):1742-1747.
14. Ginsburg PB, Grossman JM. When the price isn't right: how inadvertent payment incentives drive medical care. *Health Aff (Millwood)*. 2005(suppl Web exclusives):W5-376-W5-384.
15. Baicker K, Chandra A. Medicare spending, the physician workforce, and beneficiaries' quality of care. *Health Aff (Millwood)*. 2004(suppl Web exclusives):W4184-W197.
16. Tolkoff M. Compare your earnings with those of colleagues in your specialty and others: the news for primary care physicians is a bit better. *Med Econ*. October 2006:20 http://www.memag.com/memag/Practice+Management%3A+Compensation/Exclusive-Earnings-Survey-How-are-you-doing/ArticleStandard/Article/detail/379594. Accessed October 22, 2007.
17. American Medical Association RVS Update Committee (RUC). *AMA/Specialty Society: RVS Update Process*. http://www.ama-assn.org/ama/pub/category/16401.html. Accessed June 24, 2007.
18. Newhouse JP. Medicare spending on physicians—no easy fix in sight. *N Engl J Med*. 2007;356(18):1883-1884.
19. Ginsburg PB, Berenson RA. Revising Medicare's physician fee schedule—much activity, little change. *N Engl J Med*. 2007;356(12):1201-1203.
20. Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Promoting Greater Efficiency in Medicare*. June 2007. http://www.medpac.gov/documents/Jun07_EntireReport.pdf. Accessed October 22, 2007.
21. Garibaldi RA, Popkave C, Bylsma W. Career plans for trainees in internal medicine residency programs. *Acad Med*. 2005;80(5):507-512.
22. West CP, Popkave C, Schultz HJ, et al. Changes in career decisions of internal medicine residents during training. *Ann Intern Med*. 2006;145(10):774-778.
23. Sox HC. Leaving (internal) medicine. *Ann Intern Med*. 2006;144(1):57-58.
24. Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Assessing Alternatives to the Sustainable Growth Formula* . March 2007. http://www.medpac.gov/documents/Mar07_SGR_mandated_report.pdf. Accessed October 22, 2007.
25. Forrest CB. Strengthening primary care to bolster the health care safety net. *JAMA*. 2006;295(9):1062-1064.

OREGON PUBLIC MEETING LAWS
Guidelines for the Oregon Health Fund Board and its Committees

History
The Oregon Public Meetings Law, ORS 192.610 to 192.690 was enacted in 1973 in an effort to ensure that deliberations and decisions of governing bodies are made openly.

Definitions
Since the Oregon Health Fund Board and its Committees were created by statute, they are considered to be "*public bodies*." A "*governing body*" is a group of members of a public body with the authority to make decisions for or recommendations to a public body on policy or administration, which in the case of the Bard and its Committees is at least a quorum.

Statute defines "*decision*" as any determination, action, vote or final disposition upon a motion, proposal, resolution, order, ordinance or measure of which a vote of a governing body is required. "*Meeting*" is defined as the convening of a governing body or a public body in order to make a decision or deliberate toward a decision on any matter.

Meeting Requirements
Any time a quorum of the Board or one of its Committees meets to deliberate towards a decision, the meeting must be open to the public. Meetings cannot take place in locations which practice discrimination and must be accessible to disabled persons.

Public notices for all meetings must be provided to interested parties at least 48 hours prior to the start of the meeting. Meeting notices must include the time and location of the meeting, as well as a list of the principal subjects expected to be discussed.

A sound, video or digital recording or a set of written minutes must be taken at every meeting and must be made available to the public within a reasonable time after the meeting. The minutes must be a true reflection of the matters discussed at the meeting and the views of the participants and must include the following information: all members present; all motions, proposals, resolutions, orders, ordinances and measures proposed and their disposition; the results of all votes and the vote of each member; the substance of any discussion; a reference to any document discussed at the meeting.

Notice rules still apply to meetings held by phone or other electronic means. In such cases, at least one place will be made available to the public where the public can listen to the meeting in real time.

Public Record

All documents distributed to the Board or its Committees, discussed at meetings or produced by the Board and its Committees will be considered public record. Documents will be made available at meetings and upon request from any member of the public. Correspondence, including but not limited to, letters, memoranda, notes and electronic messages that communicate formal approvals, direction for action and information about the Board and its Committees are considered part of administrative record and thus are subject to public record requirements.

Enforcement

Decisions made the Board or its Committees in violation of the Public Meeting Laws will be voided, unless it is reinstated while in compliance. A reinstated decision is effective from the date it was initially adopted.

Oregon Health Fund Board

October 2007 Update

About the Oregon Health Fund Board

Created by SB 329 (the Healthy Oregon Act), the Oregon Health Fund Board is a 7 member board appointed by the Governor and confirmed by the Oregon Senate. The Board is developing a comprehensive plan to ensure access to health care for all Oregonians, contain health care costs, and address issues of quality in health care. The members of the Board have experience, knowledge and expertise in the areas of consumer advocacy, management, finance, labor and health care, and represent the geographic and ethnic diversity of the state. Barney Speight, Executive Director, and the staff of the Office for Oregon Health Policy and Research assist the Board.

OHFB Board Members

- **Bill Thorndike, Chair**
  CEO, Medford Fabrication
- **Jonathan Ater , Vice-Chair**
  Chair and Senior Partner, Ater Wynne LLP
- **Eileen Brady, Vice-Chair**
  Co-Owner, New Seasons Market
- **Tom Chamberlain**
  President, Oregon AFL-CIO
- **Charles Hofmann, MD**
  Physician
- **Ray Miao**
  President, Oregon Chapter, AARP
- **Marcus Mundy**
  President, Urban League of Portland

Getting Started

This month the Oregon Health Fund Board met for the first time, as did four of its six committees.

The full board met on October 2 in order to review and confirm its bylaws, elect a chair and vice-chairs, and appoint committee membership for four of the committees. Bill Thorndike, CEO of Medford Fabrication, was elected chair, and Jonathan Ater, Senior Partner and Chair of Ater Wynne, LLP and Eileen Brady, Co-Owner of New Seasons Market, were chosen as vice-chairs. At its first meeting, the board established a sixth committee: the Health Equities committee. Additional members will be appointed to the committees in order to round out membership with individuals representing consumer, small business and other viewpoints and areas of the state.

The committees met in the second half of the month, getting organized and prepared to tackle their respective health care reform topics. Committees and the full board will each be meeting once a month through the early part of 2008. In March and April, committees may meet more frequently in order to finalize recommendations for the board's review.

Staff has been busy as well, working to get the OHFB website up and running. The website will allow you to find: information about upcoming meetings, including agendas, written materials, and digital recordings of meetings; rosters of board and committee members; contact information for each committee; and links to committee reports.

Opportunity for Public Comment at Meetings

The Oregon Health Fund Board and its committees are interested in receiving public comment on health care reform and the work of the board. Approximately 30 minutes will be reserved at every meeting for public comment.

We encourage citizens to follow these guidelines:

1. Please complete the meeting sign-up sheet and indicate you wish to testify.
2. Whenever possible, submit written comments so they can be included in the official meeting records.
3. Oral comments should be limited, summary comments – 3 to 5 minutes – to permit others the opportunity to speak.
4. Comments can also be submitted by email to: OHFB.Info@state.or.us . Staff will distribute summaries of email communications to Board and committee members on a routine basis. *Thank you!*

Board Meeting Calendar:

November 6, 2007
1 pm – 4 pm
Oregon State Library
Room 103
250 Winter St. NE
Salem, OR

December 12, 2007
1 pm – 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Ctr. Loop E
Wilsonville, OR

Committee Meeting Calendar:

Benefits

November 8, 2007
9:30 am – 1:30 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Delivery Systems

November 15, 2007
1 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

December 12, 2007
1 pm – 4 pm
Wilsonville Training Center
Rooms 111-112
29353 Town Center Loop E
Wilsonville, OR
(Combined with Health Fund Board meeting)

Finance

November 19, 2007
and
December 19, 2007
1 pm -5 pm
Wilsonville Training Center
Room 112
29353 Town Center Loop E
Wilsonville, OR

Continued on Page 2

Message from Barney Speight:

About 4 months ago, Governor Kulongoski signed SB 329 (Chapter 697, Oregon Laws 2007). In the brief interval since then, the Oregon Health Fund Board has been appointed by the Governor and confirmed by the Oregon Senate, and six committees have been organized with some 90 citizens volunteering to work on various issues related to the development of a comprehensive plan to reform Oregon's health care system. The outpouring of interest and support for the work of the Board is both energizing and gratifying.

The Board and its Committees will be supported by the professional and administrative staff of the Office for Oregon Health Policy & Research (OHPR) and new personnel authorized in the Board's biennial budget. In addition, several state agencies (Human Services, Consumer & Business Services, Office of Private Health Partnerships, et al), supplemented by local and national consultants, will assist with policy research, economic modeling and related analytic work.

Guided by project charters, the OHFB committees will begin their work in November with frequent meetings into the early spring, 2008. The Board will devote its meetings of November 6 and December 12 to briefings and discussion of cost drivers in health care, current insurance regulation, the potential role of an insurance exchange and the need to transform primary care.

The Board is committed to effective public outreach and feedback. While our communications plan is being finalized, the Board's website – *healthfundboard.oregon.gov* – is a resource for meeting dates, agendas and materials distributed at meetings. The public may also send the Board comments on reform to our Salem office or by email to OHFB.Info@state.or.us. Staff will routinely monitor the email and summarize messages for the Board.

The organizational phase of SB 329 is concluding…now the difficult work of building a comprehensive plan for reform begins!

Contact Information

Executive Director Barney Speight and the staff of the Oregon Health Fund Board can be reached at:

1225 Ferry Street, SE, 1st Floor
Salem, OR 97301
Phone: 503-373-1538
Fax: 503-378-5511
Web: http://healthfundboard.oregon.gov
Email: OHFB.INFO@state.or.us

Committee Meeting Calendar (continued):

Eligibility & Enrollment

November 13
9 am – Noon
Oregon State Library
Room 103
250 Winter Street NE
Salem, OR

November 28
2 pm – 5 pm
General Services Building
Mt. Mazama Room
(In basement)
1225 Ferry Street SE
Salem, OR

December 11
10 am – 1 pm
General Services Building
Mt. Mazama Room
(In basement)
1225 Ferry Street SE
Salem, OR

Federal Laws

November 29
9:30-11:30 am
Wilsonville Training Center
Room 111
29353 Town Center Loop E
Wilsonville, OR

Health Equities

Meeting dates TBD

OREGON HEALTH FUND BOARD
ELIGIBILITY AND ENROLLMENT COMMITTEE
Approved by OHFB _____

Objective

The Eligibility and Enrollment Committee is chartered to develop recommendations for the eligibility requirements and enrollment procedures for the Oregon Health Fund program to the Oregon Health Fund Board.

Scope

The Eligibility and Enrollment Committee will focus its study of strategies to Eligibility requirements, including:

1) Affordability: public subsidies of premiums and other costs associated with the program that ensure program affordability at all incomes for individuals and sustainability for the state;
2) Enrollment Procedures: streamlined procedures, including: a standardized application process, application assistance, requirements to demonstrate Oregon residency, retroactive eligibility, waiting periods, preexisting condition limitations, other administrative requirements for enrollment;
3) Disenrollment: standards for disenrollment and changing enrollment in Accountable Health Plan;
4) Outreach: an outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and program's eligibility requirements and enrollment procedures; and,
5) ESI: process for allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

Committee Membership

Name	Affiliation	City
Ellen Lowe, Chair	Advocate and Public Policy Consultant	Portland
Jim Russell, Vice-Chair	MidValley Behavioral Care	Salem
Robert Bach	Medicaid Advisory Committee (MAC)	Portland
Jane Baumgarten	Retired	Coos Bay
Dean Kortge	Pacific Benefits Consultants	Eugene
Felisa Hagins	SEIU Local 49	Portland
Noelle Lyda	Ed Clark Insurance Inc.	Salem
CJ McLeod	The ODS Companies	Portland
John Mullin	Oregon Law Center	Portland
Bill Murray	Doctors of Oregon Coast South	Coos Bay
Ellen Pinney	Oregon Health Action Campaign	Corbett/Salem
Susan Rasmussen	Kaiser Permanente	Portland
Carole Romm	Central City Concern, MAC	Portland
Ann Turner, MD	Virginia Garcia Health Center	Cornelius

Staff Resources

- Tina Edlund, Deputy Administrator, Office for Oregon Health Policy and Research (OHPR) - Tina.D.Edlund@state.or.us; 503-373-1848 (Lead Staff)
- Heidi Allen, OHREC Director, Medicaid Advisory Committee, OHPR – Heidi.Allen@state.or.us; 503-373-1608
- Nate Hierlmaier, Policy Analyst, OHPR – Nate.Hierlmaier@state.or.us; 503-373-1608
- Tina Huntley, Assistant, OHPR – Tina.Huntley@state.or.us; 503-373-1629

Timing

The Committee will provide its recommendation(s) to the Benefits Committee on public subsidies and affordability no later than January 15, 2008 and all other recommendation(s) to the Board for review and public comment no later than April 30, 2008.

OREGON HEALTH FUND BOARD
BENEFITS COMMITTEE DRAFT CHARTER
Approved by OHFB on _____

Objective

The Benefits Committee is chartered to develop recommendations to the Board for defining a set(s) of essential health services that should be available to all Oregonians under a comprehensive reform plan. The work should be guided by the Board's "Design Principles & Assumptions". (See attached)

The work of the Benefits Committee may be accomplished through workgroups and/or ad hoc task forces as needed.

Scope

In developing recommendations for the defined set(s) of essential health services, the committee shall consider:

1) Mechanisms for setting priorities that optimize the health of Oregonians;
2) The demographic characteristics of the uninsured (e.g., age, gender, family status, income) in examining what services would best meet their needs in an affordable manner;
3) The applicability of the HSC Prioritized List of Health Services;
4) Methods for collecting and incorporating public values of those who will potentially benefit from and potentially contribute towards the cost of the defined set(s) of health services, their advocates, and those playing a role in their care;
5) The identification of sources and incorporation of unbiased, objective evidence in measuring the effectiveness of specific health interventions in achieving their desired health outcomes;
6) An emphasis on preventive care and chronic disease management;
7) Approaches that promote integrated systems of care centered on a primary care home;
8) Benefit and cost-sharing designs used by other states for subsidized programs (e.g., Washington Basic Health Plan);
9) The needs of vulnerable populations in order to reduce health disparities;
10) The definition and inclusion of services for dignified end-of-life care;
11) Education activities that further health and wellness promotion;
12) Standards of affordability based upon a calculation of how much individuals and families, particularly those with low incomes, can be expected to spend for health insurance;
13) Ways to incorporate cost-sharing that creates incentives that support the goal of optimizing the health of Oregonians.

The Board and OHPR will contract with one or more actuaries to work with the Benefits Committee in modeling affordable benefit package options for consideration.

Committee Membership

Member	Professional Affiliation	Location
Susan King, RN, Chair	Oregon Nurses Association	Portland
Gary Allen, DMD	Willamette Dental	Portland
Lisa Dodson, MD	OHSU, Health Service Commission (HSC)	Portland
Tom Eversole	Benton County Health Department	Corvallis
Leda Garside, RN, BSN	Tuality Healthcare, HSC	Hillsboro
Betty Johnson	Retired, Archimedes	Corvallis
Bob Joondeph	OR Advocacy Center	Portland
Jim Lussier	Retired, Health Policy Commission (HPC)	Bend
Susan Pozdena	Kaiser Permanente	Portland
Somnath Saha, MD	Portland Veterans Administration, HSC	Portland
Hugh Sowers, Jr.	Retired, AARP	McMinnville
Nina Stratton	Insurance Agent	Portland
Kathryn Weit	OR Council on Developmental Disabilities	Salem
Kevin C. Wilson, ND	Naturopathic Physician	Hillsboro

Staff Resources

- Darren Coffman, Health Services Commission Director, Office for Oregon Health Policy and Research - Darren.D.Coffman@state.or.us; (503) 373-1616 (Lead staff)
- Ariel Smits, MD, Health Services Commission Medical Director, OHPR, Ariel.Smits@state.or.us; (503) 373-1647
- Brandon Repp, Research Analyst, OHPR - Brandon.Repp@state.or.us; (503) 373-2193
- Nate Hierlmaier, Policy Analyst, OHPR - Nathan.Hierlmaier@state.or.us; (503) 373-1632
- Dorothy Allen, Administrative Assistant, OHPR - Dorothy.E.Allen@state.or.us; (503) 373-1985

Timing

The Committee will deliver its recommendation(s) to the Board no later than April 30, 2008.

OREGON HEALTH FUND BOARD
FEDERAL LAWS COMMITTEE CHARTER
Approved by OHFB on _____

Objective

The Federal Laws Committee is chartered to provide findings to the Board regarding the impact of federal law requirements on achieving the goals of the Health Fund Board, focusing particularly on barriers to reducing the number of uninsured Oregonians. The work should be guided by the Board's "Design Principles & Assumptions."

Scope

The Committee shall develop findings on the impact of federal laws on the goals of the Health Fund Board including, but not limited to, the following federal requirements:

1) Medicaid requirements such as eligibility categories and household income limits and Medicaid waivers;
2) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;
3) Emergency Medical Treatment and Active Labor Act (EMTALA) regulations that make the delivery of health care more costly and less efficient, and EMTALA waivers; and
4) Medicare policies that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate.
    - The Committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access.
    - The Committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

Committee Membership

Name	Affiliation	City
Frank Baumeister, MD	Physician	Portland
Mike Bonetto	Clear Choice Health Plans	Bend
Chris Bouneff	DePaul Treatment Centers	Portland
Ellen Gradison	Oregon Law Center	Corvallis
Michael Huntington, MD	Retired Physician, Archimedes	Corvallis
Julia James	Consultant	Bend
Mallen Kear, RN	Retired Nurse, Archimedes	Portland
Sharon Morris	Health Care Administrator (retired)	Grants Pass

Larry Mullins	Samaritan Health Services	Corvallis
Nicola Pinson	OR Primary Care Association	Portland
Tom Reardon, MD	Retired Physician	Portland

Staff Resources

- Susan Otter, Policy Analyst, Office for Oregon Health Policy and Research - Susan.Otter@state.or.us; 503-373-0859
- TBD, Policy Analyst
- Tami Breitenstein, Executive Assistant, Oregon Health Fund Board - Tami.Breitenstein@state.or.us; 503.373.1538

Timing

The final report of the Committee shall be delivered to the Board on or before April 30, 2008. After approval from the Health Fund Board and a period of public comment, the Committee will report its findings to the Oregon congressional delegation no later than July 31, 2008. The Committee shall request that the Oregon congressional delegation participate in at least one hearing in each congressional district on the impacts of federal policies on health care services and request congressional hearings in Washington, DC.

OREGON HEALTH FUND BOARD
FINANCE COMMITTEE CHARTER
Approved by OHFB on _____

Objective

The Finance Committee is chartered to develop recommendations to the Board for:

1. Strategies to finance a proposed comprehensive plan to expand access to uninsured Oregonians; and
2. Modifying the operation of Oregon's non-group (individual) market to provide access to affordable coverage for individuals complying with an individual mandate for coverage.

Both tasks should be guided by the Board's "Design Principles & Assumptions".

Scope

1. Financing a Comprehensive Plan

Expanded coverage through the Oregon Health Plan (Medicaid) and subsidized premiums in the non-group market will require new revenue. The Committee will evaluate revenue-generating options, including a payroll tax and a provider tax. Time permitting, the Committee may investigate additional options.

The final recommendations of the Committee should be equitable for those paying the tax, sustainable over the long-run, sufficient to meet projected costs, and optimize, where appropriate, the use of federal matching funds.

A. Payroll Tax

Starting from the recommendations of the Oregon Health Policy Commission's "Roadmap for Health Care Reform," the Committee will evaluate approaches to an employer "Pay or Play" system which (a) recognizes the financial contribution of employers that provide group coverage, and (b) requires employers not offering coverage to pay something toward the cost of health care for all Oregonians. In addition, the Committee should assume that all employers are required to establish Section 125 plans for employees to use pre-tax payroll deductions for their premium contributions.

The Committee will be supported by national and local experts with econometric modeling capabilities to provide detailed analysis of various payroll tax scenarios, including but not limited to:

- Projections of aggregate annual revenue generated at different tax rates;
- Projections over a 5-year term of the growth in revenue based on conservative estimates of the increases in taxable payrolls;

- Projections of the sustainability of this revenue source using annual increases in costs of n% over a 5-year term;
- Determining the extent to which federal matching could be used for premium assistance subsidies for Oregonians in defined income ranges;
- Evaluating the macro-economic impact of "Pay or Play" scenarios on Oregon's overall economic vitality.

B. Provider Tax

The Committee will evaluate various provider tax strategies (e.g., the State of Minnesota) to fund coverage expansions and provider reimbursement adjustments. The evaluation may include issues such as:

- Health providers (or health transactions) subject to a tax;
- Aggregate annual revenue generated under various tax scenarios;
- Projections over a 5-year term of the growth in revenue based on conservative estimates of the increases in the tax base; and
- Determining the extent to which federal matching funds could be used with this revenue source.

Pending draft recommendations from other OHFB committees, the Finance Committee will use reasonable proxy assumptions in its modeling and evaluation of both tax strategies.

C. Recovery of the Cost Shift

One of the objectives of expanding health insurance coverage to the uninsured is reduction of the "cost shift" that occurs when health care providers provide care to those without financial sponsorship or by "under-reimbursement" of public programs such as Medicaid. In theory, "near universal coverage" would substantially reduce the shifting of unreimbursed costs through moderation of price increases by health care providers and a consequent moderation in annual premium increases charged by health insurers in the group and non-group markets.

The Committee's work will include a review of and recommendations on how to monitor the potential diminution of the "cost shift" and its positive impact on provider prices and insurer premiums.

Committee Membership

The Finance Committee appointed by the Board will work as a committee-of-the-whole on "Financing a Comprehensive Plan." The Chair of the Committee may invite others with content expertise to participate with the Committee in its work. Members of the committee include:

Name	Affiliation	City
Kerry Barnett, Chair	The Regence Group	Portland
John Worcester, Vice-Chair	Evraz Oregon Steel Mills	Portland
Andy Anderson	Cascade Corporation	Portland
Peter Bernardo, MD	Physician	Salem
Aelea Christensen	Owner, ATL Communications, Inc.	Sunriver
Terry Coplin	Lane Individual Practice Association, Inc.	Eugene
Lynn-Marie Crider	SEIU	Portland
Jim Diegel	Cascade Healthcare	Bend
Steve Doty	Northwest Employee Benefits	Portland
Laura Etherton	Advocate Oregon State Public Interest Research Group	Portland
Cherry Harris	International Union of Operating Engineers	Portland
Denise Honzel	Health Policy Commission	Portland
David Hooff	Northwest Health Foundation	Portland
John Lee	Consultant	Portland
Scott Sadler	Owner, The Arbor Café	Salem
Steve Sharp	Chairman, TriQuint Semiconductor	Hillsboro

Timing

The final recommendations of the Committee on "Financing a Comprehensive Plan" shall be delivered to the Board on or before April 30, 2008.

2. Adapting the Insurance Market under a Comprehensive Plan

The Board's "Design Principles & Assumptions" portend significant changes in Oregon's non-group (individual) market. While over 200,000 Oregonians obtain coverage in the non-group market, tens of thousands of uninsured individuals will be required to seek coverage under an individual mandate. Some will be eligible for premium assistance subsidies.

The Committee (through a work group described below) is tasked to evaluate options and develop recommendations on how the private, non-group market should be organized and regulated within a Comprehensive Plan for reform. The work will include an evaluation of and recommendations on the role an "insurance exchange" would play in such an environment, including individual choice of carrier and plan and efficient administration of subsidies to eligible Oregonians.

Issues

The evaluation and recommendations will address issues including but not limited to:

Non-Group Market

- Guaranteed issue and renewability

- Standardization of benefits, product offerings
- Ensuring consistency of benefits between Exchange and external non-group market
- Implications for small group market of changes to non-group market

The Structure of an Exchange

- Organization of Exchange
- Governance structure
- Funding
- Ensuring sufficient enrollment/participation
- Role of brokers

Interaction between Subsidy and Exchange

- Who is offered subsidy
- Mandate use of Exchange for subsidy users?
- Products offered to those with and without subsidies
- Subsidy funding
- Coordination with the Family Health Insurance Assistance Program

Risk Adjustment

- Risk adjustment mechanisms
- Continue high risk pool?

Individual Participation

- Mandatory and voluntary participants
- Minimum enrollment period requirement? Enforcement mechanism
- Portability across employers and from Medicaid to employer coverage
- Use of pre-tax dollars to purchase premiums
- Supporting consumer choice via decision support tools & cost, quality, service information

Employer Participation

- Open or limited employer participation
- Employer incentives for participation
- Encouraging/maintaining employer sponsored coverage
- Premium aggregation for employees with multiple employers
- Minimum financial participation by employer for participation?

Health Plan Participation

- Inclusion of all affordable health plan options
- Allow all willing plan or limit to select group of plans
- Integrating incentives for provider compensation, transparency, medical home, EHR
- Minimum coverage requirements?

- Development of packages that manage care, quality and cost
- Appropriate use of 125 plans

Work Group Membership

A Work Group on Insurance Market Changes will be comprised of select members of the Finance Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the Work Group.

Timing

The recommendations of the Work Group on Insurance Market Changes shall be delivered to the Finance Committee on or before March 15, 2008. The Finance Committee shall consider the recommendations of the Work Group and forward final recommendations to the Board on or before April 30, 2008.

Staff Resources

The work outlined above will be supported by:

- Nora Leibowitz, Acting Director, Oregon Health Policy Commission, Office for Oregon Health Policy and Research – Nora.Leibowitz@state.or.us; 503-385-5561
- Susan Otter, Policy Analyst, Office for Oregon Health Policy and Research – Susan.Otter@state.or.us; 503-373-0859
- Alyssa Holmgren, Policy Analyst, Office for Oregon Health Policy and Research – Alyssa.Holmgren@state.or.us; 503-302-0070
- Zarie Haverkate, Communications Coordinator, Oregon Health Policy Commission, Office for Oregon Health Policy and Research – Zarie.Haverkate@state.or.us; 503-373-1574
- Local and national consultants retained by the Board or Oregon Health Policy and Research

OREGON HEALTH FUND BOARD
Delivery Committee
Health Care Quality Institute Work Group

Delivery Committee Representatives

- **Vickie Gates**, Co-Chair, Quality and Transparency Work Group, Oregon Health Policy Commission
- **Maribeth Healy**, Director**,** Oregonians for Health Security

Content Experts

Nancy Clarke
Executive Director, Oregon Health Care Quality Corporation
Member, Quality and Transparency Work Group, Oregon Health Policy Commission
Portland

Ms. Clarke leads The Oregon Health Care Quality Corporation, a nonprofit organization dedicated to improving the quality of health care in Oregon. The Quality Corporation received a recent grant from the Robert Wood Johnson Foundation to bring various stakeholders together to improve the quality of chronic care across the state through the collection and reporting of outpatient primary care healthcare performance measures in the Willamette Valley.

Richard Cohen, MD (yet to be confirmed)
Physician
Grants Pass

Dr. Cohen is a physician working in rural Oregon and serves as the IT Liaison to Three Rivers Community Hospital.

James Dameron
Administrator
Oregon Patient Safety Commission

Mr. Dameron leads the Patient Safety Commission, which works to improve patient safety throughout the state by reducing the risk of serious adverse events occurring in Oregon's health care system and encouraging a culture of patient safety.

Gwen Dayton, JD
Executive Vice President and Chief Counsel, Oregon Association of Hospitals & Health Systems (OAHHS)
Member, Quality and Transparency Work Group, Oregon Health Policy Commission
Lake Oswego

Ms. Dayton leads the OAHHS quality initiatives, which includes an effort to report on quality indicators for Oregon hospitals. She also leads education and rural initiatives for the Association.

Gil Muñoz
Chief Executive Officer, Virginia Garcia Memorial Health Center
Member, Quality and Transparency Work Group, Oregon Health Policy Commission
Portland

Mr. Muñoz is responsible for running four clinics which strive to bring accessible, high-quality and culturally appropriate care to low-income and uninsured residents of Washington and Yamhill Country.

Ralph Prows, MD
Chief Medical Officer, Regence BlueCross BlueShield of Oregon
Member, Quality and Transparency Work Group, Oregon Health Policy Commission
Portland

Dr. Prows is the medical officer for the largest insurance agency in the state and is currently leading efforts to improve quality and transparency through the use of evidence-based medicine, clinical performance measurement and health information technology.

Glenn Rodriquez, MD
Chief Medical Officer, Oregon Region
Providence Health and Services
Member, Quality and Transparency Work Group, Oregon Health Policy Commission
Portland

Dr. Rodriquez has direct operational responsibilities for quality management at Providence Oregon and is accountable for quality improvement and patient safety initiatives for the Oregon region.

Brett Sheppard, MD
Professor and Vice Chairman of Surgery, The Digestive Health Center, Pancreatic/HepatoBiliary and Foregut Units
Oregon Health and Science University
Member, Quality and Transparency Work Group, Oregon Health Policy Commission
Portland

Dr. Sheppard is the chairperson of the Quality Executive Committee of OHSU, which is responsible for quality of care at OHSU. He is also a member of the Quality and Transparency Advisory Committee for the State of Oregon and a member of the Patient Safety Commission and was a founding member of the Patient Safety Alliance.

Maureen Wright, MD
Assistant Regional Medical Director for Quality Systems, Kaiser Permanente Northwest Region

Dr. Wright is responsible for the oversight and integration of clinical and service quality and patient safety processes in the delivery of medical care at an integrated health system. She completed a fellowship in patient safety through the National Quality Forum and serves on the Oregon Patient Safety Commission.

Mike Williams (yet to be confirmed)
Attorney, William, Love, O'Leary & Powers

Mr. Williams founded a nationally recognized law firm that focuses on represented individuals who have been injured by pharmaceuticals, defective medical devices and consumer fraud.

Staff:
Delivery Committee Staff:
Ilana Weinbaum – Policy Analyst, Office for Oregon Health Policy and Research
Jeanene Smith MD, MPH – Administrator, Office for Oregon Health Policy and Research

Also:
Tina Edlund, Deputy Administrator
Office for Oregon Health Policy and Research

Ms. Edlund oversaw the analysis and public reporting of the statewide Oregon hospital inpatient quality performance measures under the direction of the Oregon Health Policy Commission and its Quality and Transparency Workgroup.

"Minimum Requirements" and "High Rating" Criteria from the PEBB Vision

Domain	(1) Medical home	(2) Evidence-Based Care	(3) Member Self-Management	(4) Service Integration	(5) Infrastructure	(6) Transparency	(7) Managing for Quality
Minimum Require-ments	Patient Satisfaction Survey for PCPs Report on % of members with a Medical Home Report PCP adoption of EMR	Data analysis to identify inappropriate tests/ procedures Identify members with asthma, diabetes, create registry Report population-level HEDIS for asthma, diabetes Implement evidence-based formulary Document provider use of SAMSHA practices	Can acquire and distribute HRA and screening info to providers Provide members with access to shared decision making tools Offer chronic care mgmt, disease mgmt, and/or medication adherence programs to support primary care Willing to coordinate health education and outreach programs with PEBB-sponsored programs	Has Behavioral Health network that includes 24/7 support to PC Has capacity to share HRA data with PCPs Has capacity to share formulary with prescribers in real-time Willing to require PCPs to complete ACIC or similar chronic care assessment tool Has internal capability or willing to collaborate for predictive modeling and case management systems Require IT acquisitions to conform to Federal CHI data standards	Information technology plan addresses primary care EMR, adoption of CHI data standards, common patient identification approach, patient e-mail, clinical registries, Computerized Physician Order Entry (CPOE), e-prescribing, predictive modeling	Require participating hospitals to report data to the Oregon Patient Safety Commission, Leapfrog, and participate in the HCAHPS survey Require participating primary care providers to report HEDIS-like measures and cooperate with patient satisfaction survey program	Has payment system in place that rewards high performance on quality, outcomes, or clinical systems Has management information system that permits periodic assessment of provider performance and qualification for incentive payment Has plan with specific implementation schedule for providing patient economic incentives for risk assessment and reduction and/or medication adherence
High Rating	Document offer of Medical Home to members Provider-level reports/accountability for screening, prevention, chronic care Measure outcomes for patients with target conditions High level of PCPs with access to EMR	Support formulary through e-prescribing, education, pricing, feedback EMR and/or registries support protocols, feedback to providers Have established guidelines for asthma, heart disease, diabetes Report measures for those conditions at population and provider level Leapfrog practices in place Training system and infrastructure supports evidence-based practice	Offer member access to EMR, including e-mail and automated reminders Providers receive HRA/screening data, develop personal health plans with patients, generate annual data on health risk reduction Patients with chronic illness have personal care plan, phone support, routine measurement Medication adherence program in place Providers actively refer to & work with decision-support tools	Has close relationship with BH network (e.g. co-location, 24/7 consultation, feedback systems, use of screening tools) Has implemented e-prescribing, including real-time formulary info to prescribers Most PCPs have EMR; can acquire lab and pharmacy data electronically, multiple providers and patients can access EMR as appropriate Can identify and intervene with high-risk patients	Over 60% of PCPs have EMR Hospitals with >150 beds have CPOE Patient-provider e-mail Master patient index or equivalent in place E-prescribing in place, including formulary & pricing access Can import HRA, screening, pharmacy, lab data to EMR and share with providers Patients can access medical record, input health information	Report chronic disease outcomes for population and by provider or clinic Develop and share provider report cards (hospitals, medical groups, individual providers) Conduct and publish annual PCP patient satisfaction survey with scores for each PCP On-line capability to share formulary, pricing and performance data with patients	Has shared incentive system in place tied to outcomes Managers and clinicians receive reporting and compensation tied to performance Can rapidly identify high-risk patients and has case mgmt system to support those patients Information system can track utilization and outcomes Capital & implementation plans support quality improvement, incentives

PEBB Guiding Principles and RFP Preferences

REVISED November 16, 2004

Background: In preparation for the release of the PEBB RFI the Board compiled a list of principles to assist potential respondents in understanding PEBB's Vision and interests. In preparation for the RFP it is important that PEBB translate these guiding principles into tangible RFP requirements and scoring elements. For the purposes of discussion, the Vision principles approved by the Board in early September are followed by draft PEBB working assumptions, RFP preferences, and requirements. This draft will be revised to incorporate the final 2007 Vision recommendations from FAACT that will be discussed at the November Board meeting.

LEGEND
PEBB Vision Principle: This language was approved by PEBB in early September for use in RFI.
PEBB Assumptions: Statements that summarize some of the concepts or conclusions reached by staff, consultants, and /or technical team from the Vision planning process.
PEBB Preferences: Statement of what PEBB would prefer to happen in the delivery system. These items will be included in RFP. Respondents who can achieve goals by 2006 would receive additional points in the RFP scoring.
PEBB Requirements: Statement about RFP parameters and examples of minimum requirements.

1. **PEBB Principle:** The Board seeks new "systems" of care that includes coordination, integration, efficiency, and accountability for care across all traditional boundaries. For example, a patient with a chronic disease should have a seamless group of providers who, as a collaborative team, all have access to the same patient information, resources, technology, and common best practices to provide the best and most efficient care. PEBB members should have a medical home that is the core of all services provided.

   PEBB Assumptions: *PEBB recognizes that these new systems of care depend on the ability of respondents to significantly and fundamentally change the way care is delivered at the primary care level. The development of a medical home for PEBB members requires care delivery team members to successfully create and support these and other critical elements of system redesign. These would include evidence based care, service integration, transparency, and technology to improve the quality of care.*

   PEBB believes that approaching change at this level of the delivery system has significant advantages over more traditional top down organizational efforts to produce meaningful and sustainable delivery system changes. In addition, PEBB acknowledges the important roles of both providers and members in achieving the Vision.

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RFP Preferences*: Preferences will be given to respondents who can best demonstrate evidence of both successful existing models and credible implementation plans that are likely to result in system changes.*

RFP Requirements*: Respondents must demonstrate ability to achieve a minimum level of priority PEBB criteria by 2006. In addition PEBB seeks to encourage incremental improvement by increasing the number of criteria required by 2007 and 2008. Successful contractors would need to meet these increased requirements each year to be considered for annual contract renewal.*

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2. **PEBB Principle**: PEBB is willing and excited to explore all options to achieve the new delivery system including statewide and community solutions. For example, PEBB may contract with insurance carriers, independent physician groups, newly created partnerships among providers and vendors, and other pilot programs to achieve an integrated approach to its Vision. PEBB is seeking to contract with providers who are willing to be partners in achieving the Vision and accountable for achieving improved results in the new system of care.

   PEBB Assumptions*: PEBB welcomes innovations and solutions from the marketplace to serve the needs of PEBB's 115,000 members and the state of Oregon. At the same time, PEBB believes that the development of integrated solutions for defined regions represents the best opportunity to move the Vision forward.*

   RFP Preferences: *Preferences will be given to respondents who are able to develop the most comprehensive solutions rather than multiple disconnected carve out options (primary care, behavioral health, wellness, etc.) Preferences will be given to qualified parties who are willing to develop strategies and "systems of care" that can produce comprehensive integrated services for PEBB members.*

   RFP preferences will be given to respondents who are able to translate PEBB's Vision work including criteria and priorities into realistic and workable innovations. These innovations may include new partnerships, operating models, and funding arrangements including incentives or others suggested by respondents.

   RFP preferences will be given to respondents who can best demonstrate evidence of both successful existing models and credible implementation plans that are likely to result in system changes.

   RFP Requirements: *Requirements will include requesting bids by counties. Respondents may respond to single county, several counties, or all counties statewide. PEBB retains the right to mix and match best solutions and negotiate with respondents to produce best overall outcome for PEBB members.*

   RFP requirements will require respondents to bid a complete set of services that provide comprehensive coverage for PEBB population served e.g. hospital in single county can respond but must include coverage of all PEBB services (primary care provider, behavioral health, wellness, etc.) to qualify for consideration.

   In the event that respondents have explored and exhausted reasonable options for developing a comprehensive set of services and are unable to do so, PEBB will allow respondents to bid on a

subset of services. Respondents will need to demonstrate how and why they chose to do so. In addition they would be required to explain how their proposed approach would address the overall preference for systems of care.

3. **PEBB Principle**: PEBB is committed to making critical, large-scale changes at all levels of the program to achieve meaningful, sustainable, results with the desired outcomes. The Board is further committed to achieving greater value for members, the state, and providers of wellness, prevention, and care. Implementing this element of the Vision requires that PEBB:

   → Dramatically shift its focus to outcomes and results.

   → Clearly articulate expectations for improved clinical and population-based outcomes (not service-based outcomes).

   → Establish benchmarks against which to measure the improved health status of PEBB members.

   → Move from financial arrangements that are focused on discounted fees to models that reward demonstrated improvements in value and health outcomes.

   PEBB Assumptions*: PEBB is willing to make program changes supported by evidence that will improve quality and outcomes. PEBB will articulate its expectations for providers related to clinical improvements and outcomes. PEBB will develop benchmarks that can be used by all stakeholders to measure the effectiveness of the 2007 Vision programs. PEBB is also willing to engage its members in information, education, and program changes. PEBB is also willing to consider plan design changes, provider selection changes, member incentives, etc. when evidence can demonstrate significant improvements in quality and health outcomes.*

   RFP Preferences: *Preferences will be given to respondents who are able to demonstrate the capabilities to produce, track and report PEBB member health status benchmarks including clinical outcomes.*

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   RFP preferences will be given to respondents who are able to provide evidence of pay for performance programs or other incentives that reward improvements in value and health outcomes.

   RFP Requirements: *Requirements will include specific minimum criteria for reporting and improvements in health outcomes over time. Contract renewals will require that contractors are able to demonstrate required incremental improvements over time.*

   RFP Requirements will include affirmative confirmation of respondent's willingness to participate in the PEBB "Council of Innovators". Building on the successes of the PEBB FACCT Technical committee and stakeholder forums, PEBB would like to create a new team that is dedicated to collaborating with PEBB on the achievement of the 2007 Vision. The Council will consist of PEBB representatives, and executive leadership, medical directors and/or other appropriate technical resources representing 2006 contractors. In addition PEBB may ask other technical experts from the public or private sector to join the Council. The new group would actively participate in the review and evaluation of PEBB's implementation of the 2007 Vision plans including criteria and benchmark reporting and monitoring as well as collaborating on the development of ongoing PEBB program improvements. RFP respondents will be asked to commit the staff resources and designate the personnel who would participate in the RFP responses.

Additional scoring preferences will be given to respondents who can demonstrate a willingness to learn, share and adapt as part of the collaborative effort with PEBB and other successful contractors.

4. **PEBB Principle:** PEBB is committed to achieving value for its members and the state, and meeting its statutory mission of "providing high quality benefits at a cost affordable to the state and employees".

   PEBB Assumptions: *PEBB does not believe that a change in the traditional "benefit program" (co-payments, coverage issues) alone can result in improved quality and affordability and therefore it is seeking changes in the delivery system that will produce greater quality and cost stabilization in the future. PEBB acknowledges that the implementation of the elements of the 2007 Vision may require additional short-term resource investment to produce the desired outcomes in quality and future cost stabilization.*

   RFP Preferences*: Preferences will be given to respondents who are able to translate PEBB's Vision into innovations that will result in improved health outcomes, member engagement and communications and more appropriate use of heath benefit dollars.*

   RFP Requirements*: Requirements will require disclosure of process measures and outcomes. RFP will require proposed funding detail and rates for comparison and scoring purposes. RFP will require that respondents provide confirmation and rates of current PEBB plan design. Respondents may also suggest changes in plan design that support the Vision. PEBB will require that respondents conduct patient satisfaction surveys and release results.*

5. **PEBB Principle**: PEBB recognizes that the different areas of the state have different resources and capabilities and encourages the development of the most effective delivery system models in each area while continuing to strive for and reward high quality care everywhere.

   RFP Preferences*: PEBB will give preference to respondents that demonstrate the greatest ability to achieve the Vision statewide or by region rather than to award preferences for the highest number of counties served.*

   RFP Requirements*: Requirements will include a minimum level of technical and programmatic requirements for every respondent regardless of region, program, or population served. PEBB will request bids by counties. Respondents may respond to single county, region(s), or all counties statewide. PEBB retains the right to mix and match best solutions and negotiate with respondents to produce best overall outcome for PEBB members.*

PROGRAM SPECIFICS

6. **PEBB Principle**: PEBB will support processes to identify and apply evidence-based benefit designs, treatments, formulary, and other services. PEBB will develop specific resources to work on evidence-based products, including reference pricing. The Vision requires that patients receive care based on the best available scientific knowledge. It should not vary from clinician, clinic, or area. The focus will change dramatically to outcomes and results. This will improve care and reduce waste. The

process and findings of evidence-based reviews are public. PEBB supports the option to decline or disallow conflict of interest in the evidenced-based process.

RFP Preferences*: Preferences will be given to respondents who can demonstrate current capabilities in applying evidence based practices as well as the most successful implementation strategies to apply evidence based strategies as appropriate (i.e. clinical guidelines, plan design innovations, evidence based formulary, incentives to reduce inappropriate variations).*

RFP preferences will be given to respondents who embrace PEBB's request for transparency by proposing opportunities to share data and collaborate on expansion of evidence-based medicine as appropriate.

RFP preferences will be given to respondents who are able to outline specific plans to incorporate evidence based clinical guidelines, reporting of evidence based progress and use of incentives to increase use of evidence based medicine in practice, plan design and incentives to improve appropriate care and reduce inappropriate clinical variations.

RFP Requirements*: PEBB will issue a minimum of two RFP's including Medical with and without prescription drugs and an RFP for a carve out prescription drug program. Requirements will include ability to meet specific program elements for comparison purposes (PEBB medical plan design and alternative plan design, prescription drug program with current PEBB Rx plan design, alternative Rx plan design and evidence based referenced priced formulary). Respondents will be asked to confirm and price these program specifications. In addition respondents will be asked to suggest plan design changes that include evidence based plan design changes or other innovations that advance the Vision.* .

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7. **PEBB Principle**: PEBB acknowledges the need for and is willing to devote technical resources to developing benchmarks, mining data, reporting on data and demonstrating short-term and long-term program results. The system operates with enhanced information technology. Technology improves access to all information and supports better clinical decision-making and patient information. PEBB believes that recognizing and rewarding high quality providers is an important goal and that investment in better information systems is a necessary and urgent precondition to implementation of comparative profiling systems.

   PEBB Assumptions*: PEBB recognizes there is considerable disparity among potential providers in the availability and use of enhanced technology platforms. PEBB also recognizes that some organizations have already made significant changes at the practice level and large capital investments towards information systems while others have only begun to make these changes and investments. PEBB believes that enhanced technology is a key component needed to achieve improvements in health outcomes and reporting.*

   RFP Preferences*: Preferences will be given to respondents who have already implemented or have demonstrated plans to implement and purchase technology platforms (EMR, E-prescribing, patient email) by 2006 and 2007.*

   RFP preferences will be given to respondents who are currently participating in regional and national technology and quality projects including electronic medical records, Diabetes Collaborative, etc.

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8. **PEBB Principle**: PEBB supports implementation strategies that apply these PEBB principles to selected health conditions, which might be chosen according to prevalence, health burden, high variation, or high cost. In addition, PEBB encourages use of patient information tools (e.g., decision support tools, second opinion services) as a "bridge" in the referral process – a way to slow down the rush to intervene and allow the patient to fully understand implications and choices.

   RFP Preferences/Requirements*: Preferences or requirements will be given to those respondents who have successfully implemented or plan to implement decision support tools by 2006 and 2007.*

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9. **PEBB Principle**: In the new delivery system, patients receive the information they need and are given the opportunity to exercise the degree of control they choose over decisions that affect them. The new system should be able to accommodate patient preferences and encourage shared decision-making. The system should also provide patient-preferred methods of communication and treatment such as e-mail, telephone, and group visits.

   PEBB Assumptions: *PEBB's greatest opportunity for success is the engagement of the member and provider at the level of care including having the appropriate tool and information at the point of decision making.*

   RFP Preferences*: Preferences will be given to respondents who can demonstrate the ability to incorporate these methods of care and communication.*

   RFP Requirements: *RFP may include requirements for specific tools by 2006 and 2007.*

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10. **PEBB Principle**: PEBB supports positive, sustained relationships between doctors and patients and supports strategies that improve the communications and quality of care actually provided through those relationships over strategies that might undermine them.

    PEBB Assumptions: *PEBB's greatest opportunity for success is the engagement of the member and provider at the level of care as opposed to more top down strategies that create barriers for both providers and members.*

    RFP Preferences*: Preferences will be given to those respondents who are best able to demonstrate strategies that engage the primary care providers and other care team staff in the development of care systems that improve quality and promote and enhance the relationship between member and provider.*

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11. **PEBB Principle**: Transparency is system-wide. All stakeholders have access to all information about health plans, hospitals, clinical practices, and costs to make decisions. The information includes safety, patient satisfaction, evidence-based practice, and quality and performance indicators.

    RFP Preferences: *Preferences will be given to respondents who are willing to move to transparency in all appropriate interactions with PEBB and PEBB members.*

    RFP Requirements: *To be determined based on FACCT recommendations on transparency and reporting of data and outcome.*

INCENTIVES

12. **PEBB Principle**: Provider and member incentives are aligned with each other. The system should provide incentives to providers to align their practice with system goals to achieve improved outcomes and quality.

    PEBB Principle: PEBB supports the use of modest financial incentives to encourage members to select evidence-based treatments. Members can be expected to pay a higher share of costs for treatments that are not supported by evidence.

    PEBB Principle: PEBB is hesitant to increase employee cost sharing purely as a means of cutting utilization without regard to evidence or effectiveness.

    PEBB Principle: PEBB seeks to balance the opportunity for members to receive care from the highest quality providers with its desire to support the providers and health organizations in local communities. Where there is good evidence that superior care is available outside of the local community, PEBB supports the use of incentives to encourage members to seek the best available care.

    PEBB Principle: PEBB is sensitive to the potential impact of strategies that might direct patients to receive care away from their local hospital and provider community and only supports such strategies where a strong likelihood of significant net benefit exists.

    RFP Preferences: *Preferences will be given to respondents who support PEBB's Vision and can demonstrate the ability to design and implement incentive programs that align PEBB's providers and PEBB members with the Vision goals.*

    RFP preferences will be given to providers who have good evidence that demonstrates significant and meaningful differences in quality and outcomes.

    RFP Requirements*: May include a minimum requirement for some level of pay for performance or incentives.*

ADMINISTRATIVE ISSUES

PEBB Assumptions*: Highest priority will be given to the RFP categories that address the Vision criteria. David Lansky will be presenting these recommendations at the November Board meeting. In addition to these priorities PEBB will also score respondents in their ability to achieve administrative and financial requirements. These would include the following elements:*

- *Funding methodology for overall program*
- *Rates*
- *Overall administration depending on approach*
- *Customer service*
- *Out of state and out of area coverage*
- *Network or provider capacity*
- *Technology requirements*
- *Other quality or reporting requirements*

Document History:

PEBB Vision Principles draft discussed at Board Meeting	09.07.2004
PEBB Vision Principles revised for RFI release	09.10.2004
PEBB RFP Guiding Principles draft presented to Board	11.02.2004
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VALUE-DRIVEN HEALTH CARE PURCHASING: FOUR STATES THAT ARE AHEAD OF THE CURVE

OVERVIEW

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August 2007

ABSTRACT: Health care purchasers, suppliers, and consumers are rallying for better-quality health care. In response, several states are pursuing value-based purchasing (VBP) initiatives that emphasize collection of quality-of-care data, transparency of quality and cost information, and incentives. In this overview of public–private VBP efforts in Massachusetts, Minnesota, Washington, and Wisconsin, the authors find that tiered premiums, pay-for-performance measures, and the designation of high-performance providers as "centers of excellence" are paying off. Minnesota, for example, has used incentives to achieve about $20 million in savings in 2006. Similarly, Wisconsin's Department of Employee Trust Funds has announced premium rate increases in the single digits for the third straight year. More research is necessary to determine the true impact of VBP, but health plans and providers are paying attention to and learning from these current efforts. (Note: Accompanying the overview report are four separate state case studies, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515778.)

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CONTENTS

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Sharon Silow-Carroll, M.B.A., M.S.W., is a health policy analyst with nearly 20 years experience in health policy research. She has specialized in researching health system reforms at the local, state, and national levels; strategies by hospitals to improve quality and patient-centered care; public-private partnerships to improve the performance of the health care system; and efforts to meet the needs of underserved populations. Prior to joining Health Management Associates (HMA) as a principal, she was senior vice president at the Economic and Social Research Institute (ESRI), where she directed and conducted research studies and authored numerous reports and articles on a range of health care issues.

Tanya Alteras, M.P.P., is a senior consultant at HMA. Formerly a senior policy analyst at ESRI, she has more than six years experience examining issues related to health care financing, expanding coverage for uninsured populations, and developing cost-effective private-public coverage options. At ESRI, Alteras conducted research on a number of topics, including health coverage for adults without children, health coverage tax credits, oral health, and state- and community-based strategies for covering the uninsured. Her focus was on strategies involving the leveraging of scarce public resources with private-sector funds.

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Health Management Associates (http://www.healthmanagement.com) is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985 in Lansing, Michigan, HMA provides leadership, experience, and technical expertise to local, state, and federal governmental agencies; regional and national foundations; multi-state health system organizations; single-site health care providers; and employers and other purchasers in the public and private sectors.

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

In an August 2006 executive order, President George Bush outlined his administration's Value-Driven Health Care Initiative. This initiative calls on employers to use four cornerstones when they purchase health insurance: interoperable health care information technology, reporting of quality-of-care measures, reporting of health care price information, and incentives for high-quality, cost-effective care. By committing to these goals, according to the administration, "Public and private employers and other stakeholders in the health care system can help bring about uniform approaches for measuring quality and cost and providing this information to consumers to help them make informed health care choices."

This emphasis on data collection, transparency, and incentives in health care purchasing is not new. It grows out of more than a decade of efforts to develop and implement "value-based purchasing" (VBP)—purchasing practices that are geared toward improving the value of health care services by holding providers accountable for both the quality and cost of services delivered to patients.

In this report, the authors examine the current and potential role of state and local governments, as well as public–private coalitions, in promoting value-driven health care. It summarizes an analysis of four major initiatives aimed at pursuing value in the health care system that are led by, or include, state agencies. (These initiatives in Massachusetts, Minnesota, Washington, and Wisconsin are examined in greater depth in four separate case studies, also published by The Commonwealth Fund.)

The **Massachusetts Group Insurance Commission (GIC),** a state entity that provides and administers health insurance and other benefits to the commonwealth's employees, retirees, and their dependents and survivors, is trying to improve provider performance through "tiering." GIC assigns its health plan members to a particular tier, based on quality and efficiency, and requires these plans to offer their members different levels of cost sharing, depending on which tier their chosen hospital or provider is designated.

The **Minnesota Smart Buy Alliance** is a group of public and private health care purchasers, including the state agencies overseeing Medicaid and public employee health benefits, along with coalitions of businesses and labor unions. The alliance is developing common value-driven principles, and its members are sharing VBP strategies.

Washington State's **Puget Sound Health Alliance,** a broad group of public and private health care purchasers, providers, payers (health plans), and consumers, is working to develop public performance reports on health care providers and evidence-based clinical guidelines.

The **Wisconsin Department of Employee Trust Funds (ETF),** the state agency that administers health benefits for state and local government employees, is pursuing value through a variety of purchasing strategies. EFT is also becoming involved in public-private collaboratives such as a statewide health data repository.

THREE MODELS OF VALUE-BASED PURCHASING

An exploration of the more advanced VBP efforts involving states, including the four selected for case study analysis, reveals three basic models, each with strengths and weaknesses.

Model 1—Single Large Purchaser: involves a large purchaser working actively and cooperatively with suppliers while using its market power to make demands. Such purchasers working alone are limited in influence but can move quickly and be pioneers.

Model 2—Purchaser Coalition: involves a group of public and private purchasers (or purchaser coalitions) working together to standardize demands on suppliers and share value-driven strategies. Reaching agreement among purchasers with different priorities can be challenging, but coalitions can leverage greater market share and wield more influence with suppliers.

Model 3—Mixed Coalition: involves a group of health care purchasers and suppliers working cooperatively to promote transparency and incentives. Reaching consensus is very difficult and time consuming, and leads to watered down strategies, but multi-stakeholder initiatives have the potential to make the most significant impact on the market.

Four State Initiatives to Improve Value in Health Care Purchasing

Value-Driven Initiative	Model	Scale
Massachusetts Group Insurance Commission (GIC)	Model 1: Single Large Purchaser	GIC is the largest employer purchaser in the state, covering more than 286,000 state employees, retirees, and their dependents.*
Minnesota Smart Buy Alliance	Model 2: Purchaser Coalition	Public and private purchaser members collectively represent almost 60 percent of state residents.
Washington State Puget Sound Health Alliance	Model 3: Mixed Coalition	This coalition includes more than 140 participating organizations, including public and private employers; health plans; physicians and other health professionals; hospitals; community groups; and individual consumers. This coalition represents more than a million covered lives, or about a third of the population in five counties: King, Kitsap, Pierce, Snohomish, and Thurston.
Wisconsin Department of Employee Trust Funds (ETF)	Model 1: Single Large Purchaser	ETF is the largest employer purchaser in the state, covering more than 250,000 active state and local employees and 115,000 retirees and their dependents.**

* http://www.mass.gov/gic/.

** http://www.pophealth.wisc.edu/UWPHI/education/conference/health_colloquium_2005_02_07/etf.ppt#330,3,Value-based Purchasing Managing thru Cost AND Quality.

STRATEGIES

Depending on the model, the sites examined for this study employed a variety of strategies that can be grouped into three main categories.

Uniform Quality Measures and Reporting Requirements. This strategy involves multiple purchasers joining together to establish standard quality measures, which are translated into standard data requirements for health plans or providers. The intent is to reduce the burden on suppliers of varied reporting requirements from purchasers (thereby enhancing cooperation); reduce confusion to employers and consumers when purchasing health care; and allow providers to focus on improving quality measures that reflect evidence-based medicine.

Transparency and Public Reporting. Transparency of quality and cost information is deemed a critical component of VBP across all of the programs examined. The initiatives involved collecting data from providers and health plans, and applying quality, efficiency, and "value" measures (a combination of quality and cost) to present comparative information. Individual purchasers (Model 1) are concerned with reporting this information to their individual employee members, which is common among large

corporations. Coalitions (Models 2 and 3) are working to build more universal repositories of data that would be available to and used by the wider public and all employer/purchasers.

Direct Incentive-Based Strategies. The third and ultimate strategy that defines VBP is the use of direct incentives—financial or non-financial rewards and penalties—to change the behavior of consumers, employers, and providers in ways that promote better quality of care, greater value for dollars spent, and improved health outcomes. Mechanisms include:

- *Tiered Premiums or Copayments.* Researchers are beginning to see variable premiums or copayments tied to the quality and performance of physician group practices, individual physicians, and hospitals.

- *Pay-for-Performance.* Programs to give extra payments ("carrots") to reward health plans or physician practices for quality improvement and patient-focused high-value care are growing, and one major purchaser is considering penalties related to poor performance ("stick") approaches.

- *Centers of Excellence.* This tactic takes public reporting one step further by selecting the best performers and giving them special designations. The expectation is that patients are more likely to select the publicly recognized hospitals and physician practices, which should result in improved health outcomes. This strategy also gives incentives to providers to improve their performance in seeking the designation. A member group of the Labor Management Coalition, a Smart Buy Alliance member, has estimated a 2.5 to 1 return on investment from its "Best in Class" program.

Combination strategies incorporate various elements of the above strategies. For example, Wisconsin's ETF centralized its pharmacy benefit into a newly developed Pharmacy Benefit Manager (PBM), using value-driven principles of transparency and incentives. ETF helped create a PBM that would have no "secret" deals with pharmaceutical manufacturers and all rebates would flow to the state. Further, the PBM would receive a bonus if the state saved money; thus, the two organizations' incentives are aligned. The PBM also developed a three-tier, evidence-based formulary and other quality/efficiency-based initiatives. The result of these pharmacy initiatives was savings estimated at $160 million across three years.

Minnesota's Department of Employee Relations (DOER), a member of the Smart Buy Alliance, purchases health care for about 120,000 public employees and their families,

and it has implemented many of the value-driven strategies described in this report. Its coverage program had a 0 percent premium increase for 2006, and about $20 million in savings is being returned to the state employees through a "premium holiday." Members who pay a health care premium will save about 4.4 percent of their total annual premium, or about $53 per employee with dependent coverage. DOER attributes the savings to lower-than-expected claims related to value-driven incentives and health promotion strategies.

CHALLENGES

While value-driven health care purchasing poses a number of exciting opportunities for reshaping the health care system into one that is more efficient and provides higher quality care, these efforts are not without significant challenges.

Many of these challenges involve achieving the critical mass to change the system. Representing a large enough portion of purchasers to maximize influence and minimize cost shifting is necessary but raises challenges of reaching agreement among disparate purchasers with different priorities. Each of the programs examined in these reports noted the difficulty of getting employers to look beyond cost and incorporate quality in their health purchasing decisions. Further, getting Medicaid on board and past federal purchasing constraints has been a difficult struggle. And all of the sites noted the ongoing challenge of getting consumers engaged, though they are trying through public awareness, education, incentives, and user-friendly tools.

Another set of challenges involves facing difficult tradeoffs and striking delicate balances. For example, the programs had to find the most effective balance between cooperating with suppliers of health care and taking a more aggressive stance. The program planners also needed to obtain support from top political leadership, but, at the same time, stay above politics to remain non-partisan. They wanted to balance the need to address multiple technological and political challenges with the need to display to their supporters results and present a business case for value-driven health care. In addition, they wanted to avoid "reinventing the wheel" by using existing national quality and efficiency standards, but they needed to add a local spin to promote buy-in. And they needed to balance academic rigor in their methodology with the need to avoid "making perfect the enemy of the good" and getting nowhere.

Finally, the value movement leaders faced challenges trying to get multiple, local initiatives to build on and support rather than duplicate each other. Other communities without histories of collaboration among stakeholders that were evident in Minnesota, Puget Sound, and Wisconsin may face additional challenges in replicating value-driven models.

Changing purchaser and supplier behavior through value-oriented strategies is a slow process, and therefore value-driven health care should be viewed as one element in a broader, comprehensive effort to improve the performance of the health care system. A few of the initiatives highlighted in this report are beginning to show results—primarily but not exclusively at an anecdotal level—in terms of reducing costs and grabbing the attention of health care providers. If these and other value-oriented initiatives around the United States can successfully overcome the obstacles so that they influence providers to enhance quality and efficiency of care, then the potential to "raise all boats" is truly there—that is, for all users of the health care system, not just the current participants of the VBP initiatives. Conducting objective, empirical evaluations of the kinds of efforts highlighted in this report is critical to fully understanding the impact of such efforts on quality of care, health outcomes, and costs. Such results will help determine whether the value-driven initiatives will spread beyond the few states that are now pursuing these efforts.

VALUE-DRIVEN HEALTH CARE PURCHASING: FOUR STATES THAT ARE AHEAD OF THE CURVE

OVERVIEW

INTRODUCTION

Growing concerns about the quality of health care and continued escalation of costs has prompted certain purchasers of health care to take a more active role in seeking value for their health care dollar. Earlier reviews of "value-based purchasing" (VBP) found a limited number of leaders, mainly among large employers and business coalitions.[1] But even large businesses are finding that their influence in promoting quality and value among health care suppliers is limited without the influence of the very largest purchasers: state or county employee benefit agencies and Medicaid.

At the same time, factors such as cost escalation, growing numbers of uninsured people, mounting evidence of substandard care, and lack of a strong national directive for health reform are pressuring states and counties to seek both efficiencies and improved quality in their health care systems. While several states have increased cost sharing for public employees, cut Medicaid eligibility and benefits, or imposed caps on spending, others are digging beneath the spending aggregates. They are trying to determine the outcomes they are getting for the money spent; the way purchasing of services could be redesigned to lower costs, reduce inappropriate care, and improve outcomes; how various services inside and outside the traditional health programs can be coordinated; and how patients with chronic illness and disability can be better served.

In short, these public purchasers are looking for ways to enhance the value of the health care they purchase. They are forming partnerships with other public and private stakeholders to place greater demands on health care providers and plans by building into their contracts data collection, evidence-based medicine, performance incentives, and new information technologies.

Many states are pursuing individual elements of VBP (such as Medicaid pay-for-performance programs), but apparently only a few are taking a broader, comprehensive approach, including some that involve partnerships between public and private entities. This report summarizes an examination and analysis of four initiatives pursuing value in the health care system that are led by or include state agencies.

BACKGROUND

In an August 2006 executive order, President George Bush outlined the Value-Driven Health Care Initiative. This initiative calls on employers to use four cornerstones when they purchase health insurance: interoperable health care information technology, reporting of quality-of-care measures, reporting of health care price information, and incentives for high-quality, cost-effective care. By committing to these goals, according to the administration, "Public and private employers and other stakeholders in the health care system can help bring about uniform approaches for measuring quality and cost and providing this information to consumers to help them make informed health care choices."[2]

This emphasis on data collection, transparency, and incentives in health care purchasing is not new. It grows out of more than a decade of efforts to develop and implement VBP—broadly defined as "any purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost."[3] Researchers Meyer and colleagues further describe VBP as follows[4]:

> The concept of value-based health care purchasing is that buyers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.

An Agency for Healthcare Research and Quality (AHRQ) guide for purchasers describes two key strategies associated with VBP[5]:

1. Change the behavior and decisions of individuals through activities such as public reporting of provider and health plan performance, consumer information campaigns, and financial incentives (e.g., selective contracting, differential cost sharing).
2. Change the performance of health care organizations and practitioners through activities such as standardizing benefits across health plans (to facilitate comparisons); requiring accreditation and reporting of National Committee for Quality Assurance's (NCQA'S) Health Plan Employer Data and Information Set (HEDIS) measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures on mortality or complication rates; encouraging adoption of

> disease management programs; monitoring reports to identify potential improvement areas; and incorporating quality standards into contracts.

Previous research on VBP has found limited impact of such initiatives. Meyer et al., found a limited number of "pioneers" acting boldly on data collection, developing financial incentives, and working with providers to promote best practices. They also found a moderate number of "dabblers" who ask providers and health plans for information but rarely use it in purchasing decisions; and "do-nothings" comprising the majority of employer purchasers who do not incorporate quality considerations into their purchasing.[6]

Similarly, in a later review of the literature published in 2003, Maio and colleagues concluded that:[7]

> Despite these [various] dissemination and education efforts, only a limited number of champions, particularly large employers and business coalitions, are actively involved in promoting quality through their purchasing decisions. Furthermore, experts believe that, although some purchasers have firmly committed to value-based purchasing, many purchasers, especially large companies, are losing interest in implementing value-based health plan programs. Although purchasers appear to be committed to gathering performance data about health plans and providers, it is unclear whether they are using this information to influence quality.

The degree to which the administration's recent emphasis on value-driven health care will spark new interest and action by employers in the private sector is yet to be seen. The federal government is trying to lead the way by ensuring that all federal agencies and those who do health care business with the government incorporate the cornerstones of health care transparency in their practices.

This study examines the current and potential role of state and local governments, as well as public-private coalitions, in promoting value-driven health care. Researchers identify and study efforts that include state or county employee benefit agencies and Medicaid, often partnering with private entities. These public purchasers and broad coalitions represent a large share of the market and, thus, have the potential to make a strong impact on the health care system.

METHODOLOGY

To conduct this study, researchers first reviewed the literature and interviewed researchers, state officials, and others to identify VBP activities that were particularly advanced or

innovative, and that involved public entities. They chose not to focus on purely private efforts or pay-for-performance (P4P) programs to avoid duplicating other research.[8] They strove for diversity in models, strategies, and region. After selecting four initiatives in consultation with The Commonwealth Fund, the researchers conducted site visits during which face-to-face meetings were held with a range of stakeholders. They included representatives of the purchasers—state employee benefit managers, Medicaid, county governments, private businesses, labor/consumer groups, and various public and private coalitions. They also included suppliers of health care—physicians, hospitals, health plans, pharmacy benefit managers, and others. These visits were supplemented by telephone interviews when necessary. An interview guide was created to ensure consistency across interviews and sites, yet allowed flexibility to address the variation in initiatives and circumstances (see Appendix).

While the primary focus was on four selected value-driven initiatives, researchers discovered additional, related value-based efforts in each of the markets. The four primary initiatives are:

1. **Massachusetts' Group Insurance Commission (GIC).** The GIC provides and administers health insurance and other benefits to the commonwealth's employees and retirees, their dependents and survivors.[9] The GIC's Clinical Performance Improvement initiative, with a focus on provider "tiering," was launched to improve provider performance and quality of care. Health plans contracting with the GIC assign hospitals, physician groups, or individual physicians to different tiers based on quality and efficiency; the tiers are tied to varying cost-sharing requirements to encourage members to select higher quality and more efficient providers.
2. **Minnesota's Smart Buy Alliance.** The Smart Buy Alliance comprises a group of public and private health care purchasers in Minnesota, including the state agencies overseeing Medicaid (Department of Human Services) and public employee health benefits (Department of Employee Relations, DOER). Also included are coalitions of businesses and labor unions who collectively represent almost 60 percent of state residents. Various member groups within the alliance developed purchasing principles and strategies such as P4P, public reporting, and designating centers of excellence to promote and reward higher value. These strategies are shared with the other members for potential implementation.
3. **Washington State's Puget Sound Health Alliance.** The alliance is an organization of stakeholders in Washington State that includes payers, purchasers, providers, and consumers of health care. Its goal is to develop substantive reforms in quality, evidence-based medicine, and purchasing that will also address rising

health care costs. The group's current focus is on developing and disseminating public performance reports on health care providers across five counties. It is also developing evidence-based clinical guidelines for conditions such as diabetes, back pain, heart disease, and prescribing of pharmaceuticals.

4. **Wisconsin's Department of Employee Trust Funds (ETF).** ETF administers health and other benefits for state and local government employees and their families. ETF is pursuing value through public reporting of health plan performance; using tiered premiums as incentives to members to purchase more efficient plans; giving financial rewards to health plans displaying favorable cost and quality; developing an innovative pharmacy benefit management model emphasizing transparency; and becoming involved in public-private collaboratives with a statewide health data repository.

This overview presents a cross-cutting analysis in which common VBP models and strategies are summarized along with factors that foster or impede their progress. In addition, researchers have prepared a case study report for each of the sites that describes the strategies in greater depth, along with how the initiatives were developed, challenges addressed, and lessons learned. The case studies also briefly describe other value-oriented efforts in each market and how they relate, build on each other, or in some cases, compete with each other. (The individual case study reports for Massachusetts, Minnesota, Washington, and Wisconsin are available from the Fund's Web site.)

While the limited sample size does not allow generalizations or conclusions about the value-driven health care movement as a whole, both this overview and the case studies can provide policymakers, purchasers, and suppliers of health care with important information about the range of models, their direction, early accomplishments, promise, and limitations of VBP in improving the performance of the health care system.

MODELS OF MARKET CHANGE EFFORTS

An exploration of the more advanced value-driven health care efforts involving states, including those selected for case study analyses, reveals three basic models. Each model has strengths and weaknesses:

Model 1: Single Large Purchaser

This model involves a large purchaser working actively and cooperatively with suppliers while using its market power to make demands. States as purchasers, representing either state employees or a Medicaid program, are in the best position for this role as the largest health care purchasers, but large private corporations can use this model as well. In this

study, Massachusetts' GIC, Minnesota's DOER, and Wisconsin's ETF fit this model and are ahead of most private purchasers in pursuing VBP strategies. These programs emphasize transparency and incentives to individual members, health plans, and providers.

- *Strengths:* A single purchaser can move more quickly; it is not slowed down by the need to reach agreement. Early successes can encourage and act as models for other purchasers.

- *Weaknesses:* This effort does not draw directly from a broader set of purchasers and presents the risk of remaining alone in the front of the pack. In addition, suppliers may cost-shift to other purchasers.

Model 2: Purchaser Coalition

This model involves a group of public and private purchasers (or purchaser coalitions) working together to standardize demands on suppliers and share VBP strategies. Minnesota's Smart Buy Alliance, a "coalition of coalitions," uses primarily incentive-based strategies.

- *Strengths:* Coalitions leverage greater market share, thereby wielding more influence with suppliers. They can more forcefully present the purchaser perspective and priorities, and different members can pursue, test, and share different strategies. The more purchasers involved in an effort, the fewer suppliers will be able to shift costs to other purchasers, and the more they will be forced to become efficient.

- *Weaknesses:* Reaching agreement given different constituencies and political leanings can be difficult; the result may be somewhat watered down strategies or demands.

Model 3: Mixed Coalition

This type of coalition involves a group of health care purchasers and suppliers working cooperatively to promote transparency and incentives. Washington's Puget Sound Health Alliance and the Wisconsin Health Information Organization, a non-profit collaborative of health care–related stakeholders, have made efforts that reflect this model.

- *Strengths:* If all major stakeholders can agree on goals and strategies and align incentives toward common objectives, there could be a significant impact on the health care market.

- *Weaknesses:* Groups that are traditionally in an oppositional relationship will take longer to reach consensus. Moreover, strategies that are finally agreed upon may be heavily watered down, rendering them ineffective in reaching goals of greater efficiency and quality.

RANGE OF STRATEGIES

The purchasers and collaboratives in the four sites examined were engaged in a range of value-driven activities. While each was unique in detail, researchers found common themes falling into three basic categories:

1. Standardization of performance measures and data requirements;
2. Transparency and public reporting; and
3. Direct incentives, including tiered premiums, cost sharing, P4P, and center of excellence designations.

In some cases, these approaches are sequential; that is, standard data requirements and quality measures are the first step toward public reporting and comparisons of provider or health plan performance. This step, in turn, can lead to the use of incentives to select or reward the better performers. But the purchasers also viewed each of these approaches as beneficial in and of themselves. Most of the strategies are based on requirements incorporated into contracts between purchasers and suppliers of health care.

Uniform Quality Measures and Reporting Requirements

This strategy involves multiple purchasers joining together to establish standard quality guidelines or measures, which are translated into standard data requirements for health plans and providers. The intent is to reduce the burden on suppliers of varied reporting requirements from purchasers (thereby enhancing cooperation); reduce confusion to employers and consumers when purchasing health care; and allow providers to focus improvement on quality measures that reflect evidence-based medicine. These standards are generally based on national measures and best practices, such as those developed by the National Quality Forum, the NQCA's HEDIS measures, the Joint Commission on Accreditation of Healthcare Organizations, the Hospital Quality Alliance, and the Leapfrog Group. Purchaser coalitions may then adapt these measures with the help of local expert groups to promote "buy in." Examples include the following:

- One goal of the Smart Buy Alliance in Minnesota is to create common performance measures across public and private member organizations, representing about two-thirds of the state's population.
- The Minnesota Bridges to Excellence program has arranged for major payers in the Minnesota market—including the large health plans—to use the same standards and criteria on diabetes care for their P4P programs (every health plan has its own form of P4P for its participating providers).

- Minnesota's Qcare initiative, endorsed by the governor, is setting standards in diabetes, hospital stays, preventive care, and cardiac care. Purchasers may then give providers financial rewards for meeting standards.
- The Puget Sound Health Alliance's Quality Improvement Committee has formed clinical improvement teams for the purpose of developing and endorsing evidence-based treatment guidelines. So far they have completed the process for heart disease, diabetes, and pharmaceutical prescribing, and are working on protocols for the treatment of back pain and depression.

Obstacles to standard measures and demands across purchasers include difficulty obtaining sensitive data from health plans, as well as technical issues related to different information systems, risk adjustment methods, and others described further below.

Stakeholders generally agreed that seeing a significant impact from these efforts may take some time; a few sites, however, are already experiencing positive outcomes. Providers who have embraced the Puget Sound Health Alliance's evidence-based guidelines for prescribing prescription drugs have reported lower drug costs by focusing more on generic drugs, as per the alliance's advice. Seattle's Everett Clinic, for example, has achieved a generic prescribing rate of 75 percent,[10] which lowered its costs to 15 percent–20 percent below the market baseline.

Transparency and Public Reporting

Transparency of quality and cost information is deemed a critical component of value-driven health care across all of the programs examined. The initiatives involved collecting data from providers and health plans and applying quality, efficiency, and "value" measures (a combination of quality and cost) to present comparative information. Individual purchasers (Model 1) are concerned with reporting this information to their individual employee members, a practice common among large corporations. Coalitions (Models 2 and 3) are working to build more universal repositories of data that would be available to and used by the wider public and all employers/purchasers. Examples include the following:

- One of the main strategies of the Puget Sound Health Alliance is to produce publicly available reports that measure quality performance of providers in five counties comprising the Puget Sound area, and potentially across Washington State. These reports will compare the quality of care provided in local clinics, medical practices, doctors' offices, and hospitals beginning in 2007, with subsequent quarterly updates.

- eValue8 is a tool that uses common specifications and criteria to collect data from health plans that choose to participate. It then compares the data on cost, quality, and value. In Minnesota, the business coalition Buyers Health Care Action Group (BHCAG) is using the program to provide member employer groups with comparative charts, analysis of each plan's strengths, and opportunities for improvement.
- The health plan-initiated Minnesota Community Measurement program broke new ground by reporting statewide results of health care quality measures across medical groups in 2004. Using guidelines developed by a local institute and data supplied by health plans, Community Measurement continues to measure, compare, and report quality standards on more than 700 provider groups and clinics across the state.[11]
- Wisconsin's Health Information Organization (WHIO) is a non-profit collaborative of managed care companies/insurers, employer groups, health plans, physician associations, hospitals, physicians, and state agencies.[12] WHIO is building a statewide, centralized health data repository based on voluntary reporting of private health insurance claims. It will be used to develop reports on the costs, and eventually, the quality of episodes of care in ambulatory settings.
- Wisconsin's Collaborative for Healthcare Quality (WCHQ), primarily physician driven, publicly reports comparative information on its member physician practices, hospitals, and health plans through an interactive Web-based tool. WCHQ's CEO Chris Queram notes that, "the measures are reported in ways that allow member groups to identify variation by physician practice and target areas for improvement."[13]

Some impact of public reporting is already evident. Health plans report they are paying attention to the publicly available data in terms of how they compare to other health plans, and how hospitals and physicians in their network compare to others (though most health plans were already assessing their network providers in various ways). Anecdotal evidence indicates that hospitals and many physicians also pay attention to how they compare to others, and they appear to be making efforts to improve their scores. Certain businesses are also reportedly using the publicly reported measures in discussions and negotiations with health plans. But in most areas, the information (particularly quality measures) is not yet used often by employers and rarely by consumers. These and other barriers are discussed further below.

One of the biggest controversies related to public reporting concerns the unit of comparison. Managed care plan comparisons have been reported for many years, with

measures developed by NCQA (including HEDIS), which set an almost universally used standard since 1991. But reporting at the health plan level has not been very helpful for either purchasers or consumers in making quality-based decisions, given the extent to which provider networks overlap. In response, clinicians, researchers, and purchaser groups (e.g., the Leapfrog Group) have developed their own measures to compare hospitals. These measures are used primarily by employers, health plans, and hospitals.

Consumers, however, are generally concerned with selecting physicians, who then admit their patients to hospitals with which they affiliate. Current efforts focusing on physician comparisons are mainly occurring at the clinic or group practice level, including the Puget Sound Health Alliance's upcoming public reports. Still, some analysts argue that in order to engage consumers on a large scale, performance should be compared across individual physicians.

A few recent efforts at this level have begun, but such assessments raise many challenges. Perhaps the largest is how to attribute quality measures and outcomes related to an entire episode of care and multiple providers to just one physician. Some have raised concerns that assessments will not reflect patient compliance and other factors over which a physician has little control, unfairly penalizing certain physicians. And appropriate measures must be developed for primary care physicians and various specialists. A few of the physician representatives interviewed for this study contend that until consistent measures can be agreed upon, quality reporting at the individual physician level will not be useful and might actually be harmful.

Incentive-Based Strategies

The third and ultimate strategy that defines value-driven health care is the use of incentives to change the behavior of consumers, employers, and providers in ways that promote better quality of care, greater value for dollars spent, and improved health outcomes. While public reporting serves as an indirect incentive to providers to improve their performance (based on the expectation that employers and consumers will choose the better performers), incentives can be taken to the next level by providing direct financial or non-financial rewards and penalties.

Adoption of this level of value-driven health care has been very slow among private businesses, even large firms. Obstacles include reluctance to antagonize workers, union contracts that prevent such strategies, assumption that health plans are providing adequate quality control, and lack of resources or interest to invest in quality measurement activities. Also, private (and many public) purchasers have focused on cost containment—

getting discounts from suppliers or shifting costs to workers—rather than trying to use their market power to affect quality or value. Indeed, health plans themselves have been implementing P4P programs for providers within their networks. Realizing that additional pressure is needed from the demand side of the market, the pioneering public and private purchasers and coalitions highlighted in this study are pursuing similar but new, innovative incentive-based techniques. Following are specific mechanisms used.

Tiered Premiums or Copayments. It is not uncommon for employers to require from workers different premium contributions based on the cost or "richness" of health plans offered. Nor is it unusual for health plans to charge higher copayments for higher cost providers. The practice of tying premiums to quality or value of health plans, however, is just being tested. Similarly, variable copayments tied to the efficiency/quality of physician group practices, individual physicians, and hospitals are just beginning to be seen. These efforts involve developing a set of quality and efficiency measures, collecting and cleaning the data, setting criteria for designation into different tiers, and establishing different cost-sharing requirements for the different tiers. Patients are "incentivized" by lower cost sharing to select higher value performers. Of course, to be effective, the cost differential must be meaningful. The purchasers in the case studies that follow are not yet employing significant differentials because planners felt it would be more prudent to ease in this new concept, given that measurement is not yet perfect. In addition, they do not want to totally antagonize suppliers of health care or consumers. Examples include the following:

- Wisconsin's ETF implemented tiered premiums for its health plans. Each health plan is assigned to one of three tiers, and member premium contributions vary according to the tier of the health plan they choose. Tier designation is based primarily on cost, though ETF is trying to shift toward greater emphasis on quality. The tiering creates incentives for state employees to choose better value health plans: after the first year, enrollment among Tier 2 plans shifted somewhat to Tier 1. Planners assert, however, that tiering is pushing the health plans to become more efficient.

Tier	Single Rate	Family Rate
1	$27	$68
2	$60	$150
3	$143	$358

- As the largest health care purchaser in Massachusetts (outside of Medicaid), the GIC has required all of the health plans with which it contracts to develop and

implement tiered cost sharing. One health plan has placed hospitals in tiers, others have developed tiers for physician group practices, and one is beginning to tier individual physicians. All of the plans are required to move to the individual physician level within three years. The challenges associated with tiering at this level are formidable and will be discussed further below. One obstacle in this market is a common consumer assumption that higher-priced providers are better; when faced with serious health problems, they may choose to spend more to get what they assume to be the "very best," which defeats the very purpose of tiering based on quality. Careful and effective education about what determines tiers could help to counter this phenomenon.

- Minnesota's DOER places primary care clinics into four tiers based on risk-adjusted costs. State employees pay lower copayments, deductibles, and coinsurance for lower-cost providers. They also pay lower copayments if they undergo a health assessment; in this way, DOER is using financial incentives to promote better health.

Pay for Performance Programs. These programs—using extra payments to reward health plans or physician practices for quality improvement and patient-focused high-value care—are integral components of the VBP strategies in Wisconsin and Minnesota. For example:

- ETF's "Quality Composite System" awards enhanced premiums to health plans displaying favorable and quality measures. The health plans are compared on HEDIS and CAHPS performance measures; ETF is considering 'stick' tactics (penalties related to poor performance) as well.
- Minnesota's Bridges to Excellence (BTE) is an employer-led P4P program for physicians used by large, self-insured employers and DOER (state employees); Medicaid plans to adopt it as well. A modification of the national BTE initiative,[14] Minnesota's program uses locally developed measures to reward physicians for optimal care in diabetes. In 2006, physicians at 9 out of 53 medical groups were rewarded with $100 bonuses for each diabetic patient that met five specific clinical measures: blood sugar count under control, LDL cholesterol under 100, blood pressure less than 130 over 80, no smoking, and daily aspirin for patients over age 40. Minnesota's BTE plans to add heart disease care in 2007. BTE uses the same metrics that the Minnesota health plans use to reward physicians in their networks, thereby promoting uniformity and minimizing the data collection burden to providers.

Centers of Excellence. This strategy takes public reporting one step further by selecting the best performers and giving them special designations. The expectation is that patients are more likely to select the publicly recognized hospitals and physician practices, which should result in improved health outcomes. This strategy also provides incentives for providers to improve their performance in seeking the designation.

- Minnesota's Best in Class program, for example, assesses program structure, processes, and clinical outcomes for high-cost specialty care such as heart care, cancer, high-risk pregnancies, organ transplants, orthopedic problems, and neurological conditions, with special emphasis on volume of patients. Certain physician practices and hospitals are then certified as "Best in Class" for specific procedures, and patients are informed of these designations through telephone assistance with specialty care referral and scheduling. This program costs a group less than $2 per member per month and is intended to steer patients to better performing providers. The Labor Management Coalition, a Smart Buy Alliance member, is promoting this initiative, and one of its member groups has estimated a 2.5 to 1 return on investment. The program has faced obstacles, however: some physician practices refuse to participate by providing data because they already have high market share and are therefore indifferent to the incentive involved, or they fear that they will not be certified. As with more general public reporting, the success of this approach depends upon evidence that consumers (and other purchasers) more often select certified providers.

Combination Strategy. When Wisconsin's ETF centralized its pharmacy benefit into a newly developed Pharmacy Benefit Manager (PBM), it used value-driven principles of transparency and incentives. ETF helped create a PBM that would have no "secret" deals with pharmaceutical manufacturers; all rebates flow to the state. Further, the PBM receives a bonus if the state saves money; thus, the two organizations' incentives are aligned. The PBM also has developed a three-tier, evidence-based formulary and other quality/efficiency-based initiatives. The result of these pharmacy initiatives has been savings estimated at $160 million across three years. Finally, the benefits of these initiatives have been extended to state residents without drug coverage. By complying with the formulary/preferred drug list, members receive the same discounts and rebates as those negotiated for state employees.

CHALLENGES TO MOVING AHEAD

The case study initiatives provide insights to obstacles and tradeoffs involved in implementing value-driven health care. Many of these challenges involve achieving the critical mass to change the system.

Bringing along the market. In the long run, successful VBP requires a change in the entire market. The more purchasers involved in an effort, the greater the influence and negotiating power and the lower the cost-shifting. According to Carolyn Pare, CEO of BHCAG, the philosophy of the Smart Buy Alliance is "about moving the needle . . . It's about influence more than direct or joint purchasing. *We want everyone buying on value, not just volume or shifting costs to others, which is not sustainable.* We're trying to optimize 'signal strength.'" These sentiments were echoed by experts in all four sites. Several of those interviewed compared creating a value-based health care system to turning around an enormous ship.

Reaching agreement among disparate purchasers. Purchasers have different priorities; e.g., Smart Buy members have found it hard to agree on strategies, so each is continuing to pursue its own but within a common set of principles, with different purchasers placing varying weight on price and different aspects of quality. One way to address this disagreement is to push for transparency, making the information available and user-friendly, and to allow purchasers and consumers to define value their own way and make decisions accordingly.

Getting employers to look beyond cost. Most employers continue to be focused on reducing their short-term health care costs as opposed to improving the quality and long-term value of care. Understandably, they are concerned with the current year's budget and prefer to focus on their own business, leaving quality improvement to the health plans, hospitals, and physicians who are the experts. It is particularly difficult to get smaller employers and unions on board. To address this difficulty, some case study participants found it helpful to conduct regional meetings around the state and allow individual employers and consumers to hear from their peers.

Further, employers generally do not have the motivation to base decisions on quality or to place financial incentives on workers (or are under contract-related constraints preventing them from doing so). Yet effective VBP requires that employers look beyond price and incorporate quality in their health purchasing decisions. They must be convinced of the benefits to themselves and their employees of using incentives to steer workers toward better value plans and providers. They may begin with providing

information, just as Minnesota groups inform workers about which specialist practices meet the Best in Class designation, but do not at this time impose financial consequences on the workers' decisions. Eventually, however, financial consequences may be necessary to change behavior in a significant way, and education can help to minimize the backlash. For example, when Wisconsin's ETF implemented tiered premiums in health plan selection, it found early resistance from workers. ETF found it very helpful to inform and educate members and unions about the new incentives and why they were being imposed; ETF then reinforced the message by reporting to workers the savings achieved.

Getting Medicaid on board and past federal constraints. Even Minnesota's very active coalition of large businesses felt it needed the state government—both state employees and Medicaid, the state's largest purchasers of health care—to really move the market. But despite interest by Medicaid officials, the program faces constraints that make certain VBP strategies more difficult. Many Medicaid programs have implemented P4P, but Minnesota officials described "extensive federal regulations providing for strict state oversight of health plan compliance to process and administrative provisions, making it difficult and cumbersome to subject the health plans to other, additional measurement tools" that promote true value. They also noted that tiered premiums or copayments tied to value in Medicaid would require federal waivers. According to Minnesota Department of Health Commissioner Cal Ludeman, federal Medicaid guidelines are "focused on quality assurance rather than quality *improvement*."

Getting consumers engaged. All sites are struggling with getting consumers to pay attention to and use comparative performance information in their selection of health plans and providers. Progress in this area requires making data easily accessible and understandable to consumers, and educating them on how to use the information. Many of the VBP strategies studied rely on some form of consumer education and decision-making support. For example, Minnesota's Best in Class program is coupled with a Patient Advocacy Support System, or "PASS." PASS advocates provide 24 hour-per-day telephone assistance with specialty care referral and scheduling; they also inform consumers about Best in Class providers, but let them decide where to go based on their own needs and priorities. Financial incentives are not tied to using the certified providers, but some groups are considering increased copayments and deductibles if individuals do not access the information, regardless of whether and how they use the information in their provider decision. Also, Minnesota is beginning a large-scale public awareness campaign to educate consumers about the principles of VBP, such as the need to become informed, active, decision-makers in their family's health care.

Another set of challenges involves striking delicate balances, or addressing tradeoffs and competing demands.

Finding balance between cooperating with and challenging the market. Even under Models 1 or 2 (purchaser-only initiatives), purchasers must still work cooperatively with suppliers. The challenge is in getting stakeholders who have traditionally been adversaries out of their "silos" to work together toward a common goal of a more effective and efficient health care system. Also, it is helpful to consider what motivates different players. Across different markets, for example, physicians tend to be competitive and want to look good compared to others, though physician associations are often opposed to public reporting and raise concerns about imperfect measures and tools. They do, however, pay attention to how they rate. Health plans and hospitals view transparency as a tool to improve quality, while purchasers want transparency to reduce costs. While they have different motivations, the four case study sites illustrate the fact that these groups can generally agree on the importance of public reporting, despite their disparate objectives. Another way to align incentives is to tie reimbursement to performance, and some sites are beginning to do this, albeit in a small way given imperfections in measurement.

Similarly, aggressiveness must be balanced with incremental change to maximize cooperation. Nearly all Wisconsin ETF health plans are in Tier 1 because planners found it important to maintain good relations with the health plans in early stages of their tiering program. Such heavy weighting on Tier 1, however, is clearly less effective in "moving" consumers and providers, and setting more stringent Tier 1 criteria as the program evolves may be wise. And while the Massachusetts GIC required all of its contracting health plans to make their entire books of business data available for the purposes of tiering, it also gave the plans flexibility in designing their tiering programs.

Obtaining support from top leadership while staying above politics. Leaders of VBP initiatives should have support from the governor but not be dependent on such support. In this way, the initiative does not automatically collapse with a change in administration. Similarly, value-driven efforts by the agency purchasing health care are much more stable if the top official is not a political appointee.

Overcoming data and technical challenges. Health plans and providers are generally protective of their pricing and discounts, so obtaining financial information on which to assess cost and efficiency can involve lengthy and wrenching negotiations. Further, the data requirements on health plans associated with the data collection efforts

reviewed for this report were quite extensive (according to one interviewee, the process in Minnesota's initiative takes a health plan approximately 1,000 hours and $100,000 to complete). This process can be particularly onerous for smaller health plans and underscores the need for purchasers to work together to standardize their data demands and reduce reporting redundancies. The plans should develop their reporting requirements with a mind toward reducing or at least rationalizing the administrative burden on plans and providers.

Once the data are obtained, technical difficulties often arise associated with multiple data systems, risk adjustment, lack of automation among various providers, and multiple coding of physicians (the same physician may have different identification numbers used for billing different health plans). These factors make assigning accurate quality and efficiency ratings extremely challenging. Even after extensive "cleaning" of data by an independent data firm in Massachusetts, for example, a few health plans noted that the data files they received post-analysis still included a number of physicians listed multiple times under different ID numbers, requiring additional time and resources to fix. Yet while an initiative can collapse under accusations of "bad data," care must be taken to avoid "making perfect the enemy of the good." That is, while an initiative must strive for perfectly clean data, it should not postpone all measurement until it attains that ideal. Clearly, a balance must be reached.

Reaching consensus on standards. Local and state initiatives must weigh the benefits of adopting nationally recognized medical standards—thus avoiding the time and expense of reinventing the wheel—against the benefits of using local experts to enhance buy-in. A compromise is to begin with national standards, but add a local spin to promote ownership. Also, several stakeholders found it very helpful to be involved in national quality initiatives such as Care-Focused Purchasing, a national data aggregation effort whose measures serve as a guide for data collection efforts behind the Puget Sound Health Alliance's public reports.[15] This involvement allowed them to participate in cutting-edge national standards development and quickly adopt them into local or state initiatives.

While national standards are growing, they are still limited. Best practices in diabetes care are nationally recognized, for example, but no such consensus has been reached on treatment for many medical conditions. The Puget Sound Health Alliance's Clinical Improvement Team is still debating a set of measures for treatment of back pain that were released by the NCQA. In addition, protocols for spine care have also been put on hold until further evidence and research are amassed.

Ensuring that multiple initiatives build on and support each other rather than duplicate efforts. When multiple public reporting initiatives are being pursued among different stakeholders (e.g., Minnesota, Wisconsin), one of the biggest challenges is minimizing duplication (resulting in confusion to the public) and maximizing collaboration. While competition may be considered healthy, funds are limited for these efforts, so communities that learn from and build on one another will make the most progress. Wisconsin's new statewide WHIO database initiative, for example, has taken the opportunity to build on existing reporting efforts rather than reinventing the wheel. Another way that Wisconsin stakeholders are trying to reduce the "noise" from multiple reporting efforts is through a new Quality Integration Steering Committee. Composed of top leaders from four health-related organizations, the group is exploring how to link the data efforts, share knowledge, and leverage structures already in place.

Balancing the need to address multiple challenges with the need to show results. All of the initiatives studied faced a difficult dilemma related to timing. On one hand, they had to face the numerous and daunting challenges described above, which naturally slowed implementation of their programs. On the other hand, the VBP planners felt under pressure to show real progress in order to keep the parties interested and supportive—both financially and in terms of sharing their data. For example, health plans and providers wanted evidence that employers and consumers were using the information reported publicly, and that they were responding to incentives, in order for their investment to be worthwhile. And purchasers wanted to see evidence that VBP leads to cost savings, despite the nearly universal acceptance among interviewees that reducing costs was not a short-term goal of VBP efforts.

In other words, for the initiatives to be self-sustaining, the planners need to measure progress and success so they can make a business case for VBP. But in addition to the many obstacles noted above, all of the initiatives rely on voluntary adoption of common (or at least compatible) practices, filtering down multiple layers. For example, Minnesota's Smart Buy Alliance encourages agreement and adoption of strategies first at the broad alliance level, then filtering down to member coalitions; to member employers and union groups; to individual employees and consumers. Because of these multiple layers, the value-based strategies are at great risk of not being adopted on a large scale and will not show results fast enough to maintain interest and support in the initiative.

While there is no easy solution to these timing-related dilemmas, a helpful approach is to limit the focus of the VBP. This involves keeping the priorities to a reasonable number and zeroing in on issues that are most important to members; that is,

keeping the goals specific and do-able. The Smart Buy Alliance, for example, has determined that it must develop a business plan with concrete deliverables. At the same time, participants must view the initiatives as "works in progress" that require ongoing monitoring and change. If the impact is slow or less than hoped for, planners and stakeholders must not give up, but rather examine what needs to be modified.

History of collaboration and replicating value-driven health care models. One question that arose in three of the four sites studied (Minnesota, Puget Sound, and Wisconsin) was whether these value-driven models could be replicated in states and communities that do not have such histories of collaboration among stakeholders. Personal relationships among stakeholder representatives, and the ability to build on prior collaborations, helped to hold these newer efforts together. Nevertheless, a general view among participants was if strong leadership and political will is present, value-driven strategies can indeed be replicated in regions without such histories of collaboration, though they may take a little longer to get up to speed. In Massachusetts, for example, little prior stakeholder collaboration existed, but a very strong-willed leader of an organization with tremendous market power was able to get the ball rolling. Also, while value-driven health care champions are needed to jump start all of the initiatives, sustaining market movement require getting beyond the key personalities to have value-driven commitment institutionalized within organizations.

THE FUTURE OF VALUE-DRIVEN PURCHASING

Two of the state employee agencies examined in this study report measurable savings resulting from their VBP initiatives. For example, Minnesota's DOER reports that its incentive-based strategies, combined with its disease management focus, has contributed to 0 percent premium increase for 2006 and about $20 million in savings being returned to the state employees through a "premium holiday." Similarly, in August 2006, Wisconsin's ETF announced that premium rate increases had averages in the single digits for the third year in a row. However, over the same period the growth in average insurance premiums nationwide also moderated, which was attributed to a sharp drop in prescription drug spending growth, lagged effects of earlier years' slowing in cost growth, and a turn in the insurance underwriting cycle.[16]

More time and objective research are necessary to determine the true impact of the value-driven strategies in place, as well as those just being developed and implemented, on use of best practices, health outcomes, and efficiencies in the long term.

Although it is too early to measure in a quantifiable way the impact of most of the VBP initiatives reviewed in this study, purchasers expressed that they are seeing a change in the health care provider "culture." Health plans and providers are paying attention, and many of them are using the information for their own quality improvement efforts. Many stakeholders cited the Institute of Medicine's 2005 report, *Performance Measurement: Accelerating Improvement,* indicating that its call to pursue value and quality in health care is being heard.

If these purchasing initiatives can overcome the obstacles discussed in this report so they can continue to influence providers to enhance quality and efficiency of care, the potential to "raise all boats" is truly present—that is, not only for the current participants of the value-driven initiatives but for all users of the health care system. ETF's Nancy Nankivil Bennett, director of strategic health policy, Wisconsin Department of Employee Trust Funds, points out that the initiatives "result in clinical and administrative improvements that likely extend beyond ETF patients."

But keeping providers and health plans engaged requires that they see evidence that consumers and employers are paying attention and using the information. Tracking this evidence will require greater investments in consumer education and decision support. It will also require measuring, documenting, and presenting early evidence of successes and savings to employers—that is, making the business case for value-driven health care.

The ongoing decline of the traditional employer-based health coverage system and growth of employer adoption of consumer-driven health plans reinforce the need to provide consumer decision-making support. The data collection and public reporting that are key components of VBP can help provide critical tools for consumers to purchase care based on value.

VBP can also play an important role in state coverage reforms. As states such as California, Vermont, and the states discussed in this report and others experiment with health reforms involving purchasing pools and public-private partnerships, new opportunities have arisen to build VBP into these initiatives. The GIC leader and "champion," for example, plays a role in Massachusetts's broader health care reforms.

And finally, the federal government can support value-driven health care through a variety of policies and investments, including the following:

- *Easing of requirements on Medicaid regarding health plan reporting and establishing a fast-track waiver so states can more easily adopt value-driven tools and strategies.* These changes must be balanced, however, with adequate protections to ensure that new flexibility is not abused that would diminish coverage to Medicaid enrollees or impose penalties for meeting criteria beyond the control of enrollees;
- *Providing financial support and technical assistance to regional groups/collaboratives that need reliable research and information on quality and efficiency.* This support may include convening conferences to promote replication of successful or promising value-driven initiatives and funding evaluations. Also, Quality Improvement Organizations (QIOs), which work with consumers, physicians, hospitals, and other caregivers to ensure that patients get "the right care at the right time,"[17] may refocus to provide technical assistance for collection and use of information. The governance of QIOs may be expanded to include more stakeholders; one case study participant suggested that existing multi-stakeholder groups actually become the QIOs. In this way, QIOs would be more "organic," driven from within the community instead of imposed from without;
- *Providing ongoing assistance with health information technology that is necessary for reliable and timely reporting of data.* The most significant examples of this are the Medicaid Transformation Grants (MTGs), authorized by the Deficit Reduction Act, which are funding states to adopt innovative methods for improving the effectiveness and efficiency of their Medicaid programs. Almost all states that applied for and received MTGs are planning to use them to develop health information technology systems. In January 2007, $103 million in awards were announced; and
- *Continuing the move toward value-driven health care in Medicare, and allowing Medicare to be involved in regional or state level public–private value-driven pilots and initiatives.* Examples include establishing uniform quality standards and data requirements on health plans and providers to avoid confusion and administrative burdens, participating in public data repositories, and generally aligning purchasing principles and reimbursement policies with incentives to promote high value care.

As promising as VBP may be, its limitations must be underscored. As suggested in this report and the accompanying case studies, a considerable amount of time must be available for VBP initiatives to gain significant participation and reach the critical mass needed to make an impact on their local market. The case study sites highlighted in this report have a good head start, but replication in other regions that have different histories and cultures may be more challenging. The value-driven health care movement will be

further slowed by attempts to address the technical and other formidable challenges described in this report.

Because most results of value-driven initiatives to date are at an anecdotal level, it will be critical to conduct objective, empirical evaluations of these efforts to fully assess their impact on quality of care, health outcomes, and costs. Indeed, seeing measurable impact on cost and quality will come slowly and in some cases will not be seen at all in the short term (particularly given new investments in health information technology, data collection, analysis, etc.). Therefore, VBP must be viewed as an important element in a broader, more comprehensive effort to improve the performance of the health care system. Such an effort should include demand and supply-side quality improvement initiatives, and it should be integrated with comprehensive coverage, access expansion, and cost-containment strategies.

APPENDIX. MASTER* INTERVIEW GUIDE

Value-Oriented Purchasing to Improve Health System Performance

I. Interviewee Information

- A. Name/Title/Role?
- B. Organization?
- C. Role in initiative (e.g., public or private purchaser, health plan/provider, evaluator, etc.)?

II. Definition and Motivation

- A. How do you define "value"? How do you define "value-based purchasing"?
- B. What was the key impetus or trigger behind this value-oriented purchasing strategy (e.g., large variation in outcomes or practice patterns, premium spike, a fiscal crisis or legislative event)?
- C. Who took the lead in its development (e.g., agencies/organizations/individuals)?

III. General Strategy

- A. How would you describe the general strategy?
- B. What was the overarching objective?
  - o E.g., reduce costs to state/employer/consumer; improve patient/employee satisfaction, quality of care, health outcomes, efficiencies, "value," expand access to care/coverage.
- C. What is its scope? How many lives does the purchasing strategy involve?
  - o If state government, what populations are involved (e.g., state employees, Medicaid, SCHIP, mental health)? Which agencies/departments participate?
  - o Have you partnered with other public or private purchasers? Which ones?
  - o What do you think is the minimum volume needed to achieve the purchasing clout to make the strategy work?
- D. Was your initiative built upon or enhanced by "pay for performance" or "value-based purchasing" developments in other sectors? Was it motivated by these developments in other states, or by other purchasers in your state?
- E. Is there overlap or competition with other similar initiatives? If so, does that help or hinder your efforts? Describe.

* *Note: Guide will be tailored to the particular program and organization/individual.*

IV. Initiative Components

What are the strategy's key components? FOR EACH . . .

Mechanism

A. Description of mechanism: e.g., tiered networks (varied copays/cost-sharing), setting uniform performance standards, cost/quality reporting requirements, information technology demands on health plans and providers; favor providers and health plans that are certified for highest quality . . .

B. What is the primary focus (e.g., costs, performance, other)?

C. What is the role of contracting? E.g., have you built the new standards, demands or incentives into RFPs? . . . into contract negotiations?

D. Is there involvement by other stakeholders? Describe.

Data Collection and Measurement

E. What types of performance measures are being used? (e.g., satisfaction, clinical outcomes, other)?

   i. Do you now or plan to collect or slice data by race, ethnicity, gender, income, geography, or other potential indicators of disparity?

   ii. What was the selection process? Did you base the measures on established standards (e.g., HEDIS, Leapfrog, CAHPS, other)?

   iii. How and by whom are they being measured? How do they go about reporting it?

   iv. Did you find that IT was necessary? If so, how was it developed, financed?

F. What are the performance goals?

   i. Are any benchmarks (national, regional, or hospital-based)?

   ii. Are evidence-based clinical guidelines or "best practices" used?

   iii. Are goals set for your health plans/providers related to meeting an absolute "score," making a certain percentage improvement over past performance, or other threshold?

G. Does the strategy involve providing comparative information to consumers? . . . to providers/others? How do you assure that information is accurate and up-to-date? . . . appropriate for that audience? . . . used by that audience?

Use of Incentives/Pay-for-Performance

H. Role of incentives: To what extent do you use rewards (carrots) vs. punishments (sticks)?

I. To whom are the incentives targeted (enrollee/employee/patient, physician, hospital, health plan, other)?

- What was their reaction to the new purchasing strategy?
- What is at stake: e.g., financial bonus or withhold, percent of premium, steering patients to certain plans through differential premiums or auto-assignment?
- Is this enough incentive to change [provider or consumer] behavior?
- If not, what would be a better incentive level that would change behavior?

J. Other than incentives, are there other ways you have held providers/ health plans accountable for high quality or efficiency?

V. Key Ingredients behind: 1) Implementation, 2) Success, and 3) Sustainability

A. What were the key factors needed to get the program going? Probe re: leadership, collaboration, purchaser volume/clout, IT, cost or quality crisis?

B. What steps did you go through in order to get to this point (e.g., stage 1—data reporting; stage 2—process outcomes, stage 3—financial incentives, etc.)?

C. If a collaboration, how was it created and nurtured? Who are the members?

D. What are the key factors for achieving success? Probe as above.

E. What are the key factors for sustaining and expanding the program? Probe as above.

VI. Accomplishments and Outcomes

A. How is progress assessed?

B. Have you examined process outcomes: e.g., impact on reporting and use of performance-related data among patients and health plans; choosing or contracting with higher-performing health plans or providers; administrative or clinical programs to improve indicators that are not up to standards; changes in care-seeking behaviors, patient satisfaction?

C. Have you measured "final outcomes" if any at this stage, e.g., changes in health outcomes, costs, other? I.e., does your experience make the business case for quality or value?

D. What outcomes are expected, and when?

E. Is there any indication that process or outcome changes related to this program extend beyond this population, toward systemwide reforms? Describe.

VII. Challenges

A. If public purchaser: Would you share with us major barriers to implementation? Probe re: political, legislative, bureaucratic, other constraints.

B. If private purchaser: Would you share with us major barriers to implementation? Probe re: union, management, competition, lack-of-volume, privacy laws, other constraints.

C. Were there certain environmental barriers (political, regulatory, market-related)?

D. What is the organizational focus (e.g., health plan/individual provider/care system) for value purchasing? Are there limitations of that organizational focus for value purchasing?

E. Any professional (e.g., health plan, provider) resistance to comparisons based on quality or costs?

F. Any public/enrollee resistance to or lack of interest in comparisons based on quality or costs?

G. Any employer resistance or lack of interest in quality (vs. cost alone), or reluctance to impose financial incentives or limits on workers?

H. Any resistance to data collection and reporting? Any technical difficulties/barriers with data collection?

I. Inadequate staff, or hardware/IT to do this? Any needed change of mind-set among your internal staff to focus on value?

J. Any other major obstacles or challenges faced?

K. For each obstacle, how was it addressed? Was it successfully overcome?

VIII. Next Steps

A. What are your plans for the future? E.g., will you continue or build on these purchasing strategies? Describe upcoming strategies, implementation plan.

B. Do you anticipate any barriers to these plans?

C. What would help ensure the success of these plans?

IX. Lessons and Recommendations

A. Are there any lessons you or your organization have learned in trying to purchase health care based on value? Describe.

B. Are there certain purchasing practices that you've experienced that you would NOT recommend for replication? Why?

C. Are there strategies that you think are successful but not replicable elsewhere? Why/why not?

D. What purchasing strategies developed or used here WOULD you recommend be adopted by other organizations? What kinds of organizations would be appropriate (Medicaid programs, state employees, private businesses, coalitions, other)?

E. What would be the best ways to get that message and those strategies to others? I.e., how can lessons be effectively disseminated to and adopted by those who are not pioneers?

F. Are there any policy changes that might contribute toward replication, expansion, or incorporating these strategies into broader delivery system reform?

   - How could state legislators/federal policymakers/researchers/ grantmakers play a role? E.g., regulations, technical assistance, clearinghouse of best practices?

NOTES

[1] Agency for Healthcare Research and Quality, *Evaluating the Impact of Value-Based Purchasing: A Guide for Purchasers,* AHRQ Publication No. 02-0029 (Rockville, Md.: AHRQ, May 2002); V. Maio, N. I. Goldfarb, C. Carter et al., *Value-Based Purchasing: A Review of the Literature* (New York: The Commonwealth Fund, May 2003).

[2] See U.S. Department of Health and Human Services, http://www.hhs.gov/transparency/goverment/index.html.

[3] AHRQ, *Evaluating the Impact,* 2002.

[4] J. Meyer, R. Lise, and R. Eichler, *Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers* (Rockville, Md.: AHRQ, Nov. 1997).

[5] AHRQ, *Evaluating the Impact,* 2002.

[6] Meyer et al., *Theory and Reality,* 1997.

[7] Maio et al., *Value-Based Purchasing,* 2003.

[8] See for example L. Duchon and V. Smith, *Quality Performance Measurement in Medicaid and SCHIP: Results of a 2006 National Survey of State Officials* (Health Management Associates for National Association of Children's Hospitals, Sept. 2006); K. Llanos, J. Rothstein, M. B. Dyer et al., *Physician Pay-for-Performance in Medicaid: A Guide for States* (Lawrenceville, N.J.: Center for Health Care Strategies, Apr. 2007); K. Kuhmerker and T. Hartman, *Pay-for-Performance in State Medicaid Programs: A Quantitative and Qualitative Survey of State Medicaid Directors and Programs* (New York: The Commonwealth Fund, Apr. 2007); *Pay for Performance: A Decision Guide for Purchasers* (Rockville, Md.: AHRQ, Apr. 2006).

[9] The GIC also administers benefits for Housing and Redevelopment Authority personnel; City of Springfield employees and retirees; and retired municipal employees and teachers in certain governmental units.

[10] It should be noted that Everett Clinic staff served as leaders on the pharmaceutical-prescribing Clinical Improvement Teams and were already focusing on generics before the alliance's guidelines were released.

[11] Founding members of Community Measurement include the Minnesota Medical Association and seven nonprofit Minnesota health plans (Blue Cross and Blue Shield of Minnesota/Blue Plus, First Plan of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne, and UCare Minnesota). See http://www.mnhealthcare.org/~main.cfm.

[12] State agencies joined the group in 2006 when Governor Jim Doyle signed the Health Care Transparency Bill (AB 907), authorizing the state to compile a new database in partnership with WHIO.

[13] Personal communication, Sept. 2006.

[14] For more information, see http://www.bridgestoexcellence.org/bte/.

[15] For more information, see http://www.mercerhr.com/pressrelease/details.jhtml;jsessionid=SNYMZ5UBI4W34CTGOUFCHPQKMZ0QUJLW?idContent=1239135.

[16] P. Ginsburg, B. Strunk, M. Banker et al., "Tracking Health Care Costs: Continued Stability But at High Rates in 2005," *Health Affairs* Web Exclusive (Oct. 3, 2006):w486–w495; *Health Cost Trend Remains Stable at 7-8 Percent* (AHIP Center for Policy and Research, Nov. 2006).

[17] QIOs are overseen by the Centers for Medicare and Medicaid Services. Currently, 53 QIOs are responsible for each U.S. state and territory, as well as the District of Columbia.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.commonwealthfund.org.

States in Action: A Bimonthly Look at Innovations in Health Policy. Newsletter.

Value-Driven Health Care Purchasing: Case Study of the Massachusetts Group Insurance Commission (August 2007). Tanya Alteras and Sharon Silow-Carroll.

Value-Driven Health Care Purchasing: Case Study of Minnesota's Smart Buy Alliance (August 2007). Sharon Silow-Carroll and Tanya Alteras.

Value-Driven Health Care Purchasing: Case Study of Washington State's Puget Sound Health Alliance (August 2007). Tanya Alteras and Sharon Silow-Carroll.

Value-Driven Health Care Purchasing: Case Study of Wisconsin's Department of Employee Trust Funds (August 2007). Sharon Silow-Carroll and Tanya Alteras.

Lessons from Local Access Initiatives: Contributions and Challenges (August 2007). Karen Minyard, Deborah Chollet, Laurie Felland, Lindsey Lonergan, Chris Parker, Tina Anderson-Smith, Claudia Lacson, and Jaclyn Wong.

An Analysis of Leading Congressional Health Care Bills, 2005-2007: Part II, Quality and Efficiency (July 2007). Karen Davis, Sara R. Collins, and Jennifer L. Kriss.

Quality Matters: Payment Reform (July 2007). Newsletter.

Aiming Higher: Results from a State Scorecard on Health System Performance (June 2007). Joel C. Cantor, Cathy Schoen, Dina Belloff, Sabrina K. H. How, and Douglas McCarthy.

Pay-for-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs (April 2007). Kathryn Kuhmerker and Thomas Hartman.

State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers (January 2007). Alice Burton, Isabel Friedenzohn, and Enrique Martinez-Vidal.

Creating Accountable Care Organizations: The Extended Hospital Medical Staff (December 5, 2006). Elliott S. Fisher, Douglas O. Staiger, Julie P. W. Bynum, and Daniel J. Gottlieb. *Health Affairs* Web Exclusive (*In the Literature* summary).

State Policy Options to Improve Delivery of Child Development Services: Strategies from the Eight ABCD States (December 2006). Neva Kaye, Jennifer May, and Melinda Abrams.

Value-Based Purchasing: A Review of the Literature (May 2003). Vittorio Maio, Neil I. Goldfarb, Chureen T. Carter, and David B. Nash.

How Does Quality Enter into Health Care Purchasing Decisions? (May 2003). Neil I. Goldfarb, Vittorio Maio, Chureen T. Carter, Laura Pizzi, and David B. Nash.

OREGON HEALTH FUND BOARD
DELIVERY SYSTEM COMMITTEE
By-Laws
Adopted by OHFB October 30, 2007

ARTICLE I
The Committee and its Members

- The Delivery System Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.

- Coordinate meeting agendas after consultation with Committee staff.
- Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
- Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
- The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
  - Perform any other duties assigned by the Chair.

ARTICLE IV
Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [*healthfundboard.oregon.gov*] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE V

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.

OREGON HEALTH FUND BOARD
DELIVERY SYSTEM COMMITTEE CHARTER
Approved by OHFB _____

Objective

The Delivery Committee is chartered to develop policy options and recommendations to the Board for strategies to create a high performance health system for Oregon, which provides timely, efficient, effective, high value, safe and quality health care.

The Committee will have one focused work group to develop a health care quality institute for the state.

Scope

The Committee will study, review, discuss, take public comment on and develop policy options for a package of recommendations designed to contain costs, while improving health outcomes and improving the experience of care. The Committee will focus its efforts on proposals to:

1) Revitalize primary care for the management of preventive and chronic care services;
2) Improve health information infrastructure; and
3) Create greater transparency of comparative information on health care costs and quality for providers, purchasers and consumers.

Based on this work, the Committee will recommend approaches to move towards more effective and efficient delivery system models designed to meet the health needs of all Oregonians and will describe the state's role in incentivizing accountable health plans that support these new delivery system models. The Committee will also use input from the work group to make final recommendations to the Board about the state's role in recommending quality standards, reducing costs and encouraging value-based purchasing through a health care quality institute. The Committee's work will build on the efforts and best practices of groups across Oregon, as well as successful initiatives in other states.

Committee Membership

Name	Affiliation	City
Dick Stenson, Chair	Tuality Healthcare	Hillsboro
Maribeth Healey, Vice-Chair	Advocate	Clackamas
Doug Walta, MD, Vice-Chair	Physician	Portland

Vanetta Abdellatif	Multnomah County Health Department , Health Policy Commission (HPC)	Portland
Mitch Anderson	Benton County Mental Health	Corvallis
Tina Castanares, MD	Physician, Safety Net Clinic	Hood River
David Ford	CareOregon	Portland
Vickie Gates	Consultant, HPC	Lake Oswego
William Humbert	Retired Firefighter	Gresham
Dale Johnson	Blount International, Inc.	Portland
Carolyn Kohn	Community Advocate	Grants Pass
Diane Lovell	AFSCME, PEBB Chair	Canby
Bart McMullan, MD	Regence Group of Oregon	Portland
Stefan Ostrach	Teamsters, Local 206	Eugene
Ken Provencher	PacificSource Health Plans	Eugene
Lillian Shirley, RN	Multnomah County Health Department	Portland
Mike Shirtcliff, DMD	Advantage Dental Plan, Inc.	Redmond
Charlie Tragesser	Polar Systems, Inc.	Lake Oswego
Rick Wopat, MD	Samaritan Health Services, HPC	Corvallis

Staff Resources

- Jeanene Smith, Administrator, Office for Oregon Health Policy and Research (OHPR) - Jeanene.Smith@state.or.us; 503-373-1625 (Lead staff)
- Tina Edlund, Deputy Administrator, OHPR – Tina.D.Edlund@state.or.us; 503-373-1848
- Ilana Weinbaum, Policy Analyst, OHPR – Ilana.Weinbaum@state.or.us; 503-373-2176
- Zarie Haverkate, Communications Coordinator, OHPR – Zarie.Haverkate@state.or.us; 503-373-1574

Timing

The Committee will deliver its analysis and findings to the Board for review and public comment no later than April 30, 2008.

Health Care Quality Institute Work Group

Scope

In order to achieve a high-value health system delivery system and contain costs, the state must work with providers, purchasers, and individuals to improve quality and transparency. The health care quality institute work group will make recommendations on the state's role in building on existing efforts to develop a public-private institute to coordinate the creation, collection and reporting of cost and quality information to improve health care purchasing and delivery. The work group's recommendations will address:

- How should a quality institute be organized and governed? How will it coordinate with individual stakeholder efforts and support collaboration?
- How should a quality institute be funded in the short and long term?
- How should cost and quality data be collected and stored in a central location?
- What state regulations should be examined for opportunities to increase efficiency and reduce administrative cost?
- How can a quality institute foster provider capacity to collect data and use it for improvement?
- What dissemination formats will make information useful to a broad range of audiences?
- How should a quality institute address issues of legal discovery and liability?
- What role can a quality institute play in engaging Oregonians to use available data when making health care decisions?
- How can the state encourage stronger, more coordinated statewide value-based purchasing? How can the state strengthen its own efforts to use value-based purchasing to improve delivery of care for state employees and people in the Oregon Health Plan?

Work Group Membership

The health care quality institute work group will be comprised of select members of the Delivery Committee with expertise and interest in this topic. The Chair of the Committee may appoint additional members to the work group.

Staff Resources

Jeanene Smith, Administrator, OHPR
Tina Edlund, Deputy Administrator, OHPR (Lead staff)
Ilana Weinbaum, Policy Analyst, OHPR
Zarie Haverkate, Communications Coordinator

Timing

The work group will deliver its analysis and findings to the Delivery Committee for review by February 2008.

Oregon Health Fund Board
Benefits Committee
Members Appointed as of October 2, 2007

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

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

Tom Eversole
Public Health Administrator, Benton County
Corvallis

Leda Garside, RN, BSN
Registered Nurse, Tuality Healthcare
Lake Oswego/Hillsboro

Betty Johnson
Retired
Member, Archimedes Movement
Corvallis

Bob Joondeph
Executive Director, Oregon Advocacy Center
Portland

Susan King, RN
Executive Director, Oregon Nurses Association
Portland

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

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

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

Nina Stratton
Insurance Agent and Owner, The Stratton Company
Portland

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

Oregon Health Fund Board
Delivery System Committee
Members Appointed as of October 2, 2007

Vanetta Abdellatif
Director of Integrated Clinical Services, Multnomah County Health Department
Member, Oregon Health Policy Commission & Safety Net Advisory Council
Portland

Mitch Anderson
Director, Benton County Mental Health Program
Corvallis

Tina Castanares, MD
Physician, La Clinica Del Carino Family Health Care Center
Hood River

David Ford
CEO, CareOregon, Inc.
Portland

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

Maribeth Healey
Director, Oregonians for Health Security
Member, Archimedes Movement
Clackamas

Diane Lovell
Staff Representative, Association of Federal, State, County and Municipal Employees
Chair, Oregon Public Employees' Benefits Board
Canby

John Barton (Bart) McMullan, Jr., MD
President, Regence BlueCross BlueShield of Oregon
Portland

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

Ken Provencher
President and CEO, PacificSource Health Plans, Inc.
Member, Oregon Safety Net Advisory Council
Eugene

Steve Sharp
Chairman, TriQuint Semiconductor
Member, Oregon Health Policy Commission
Hillsboro

Lillian Shirley, RN
Director, Multnomah County Health Department
Portland

Richard Stenson
President and CEO, Tuality Healthcare
Member, Medicaid Advisory Committee
Hillsboro

Douglas Walta, MD
Physician, Gastroenterologist
Portland

Rick Wopat, MD
Vice President and Chief Quality Office, Samaritan Health Services
Member, Oregon Health Policy Commission & Medicaid Advisory Committee
Lebanon

Oregon Health Fund Board
Eligibility & Enrollment Committee
Members Appointed as of October 2, 2007

Robert Bach
Lattice Semiconductor Corporation
Member, Medicaid Advisory Committee
Portland

Dean Kortge
Senior Insurance Specialist, Pacific Benefits Consultants
Eugene

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

Carlton James (CJ) McLeod
Senior Vice President and Chief Marketing Office, The ODS Companies
Portland

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

Ellen Pinney
Health Policy Advocate, Oregon Health Action Campaign
Corbett/Salem

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

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

Mike Shirtcliff, DMD
Dentist and CEO, Advantage Dental Plan, Inc.
Member, Medicaid Advisory Committee
Redmond

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

Oregon Health Fund Board
Federal Laws Committee
Members Appointed as of October 2, 2007

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

Mike Bonetto
Vice President of Planning & Development, Clear Choice Health Plans
Bend

Chris Bouneff
Director Marketing and Development, DePaul Treatment Centers
Portland

Ellen Gradison
Attorney, Oregon Law Center
Corvallis

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

Julia James
Consultant
Bend

Mallen Kear, RN (ret.)
Leader, Eastside Portland Archimedes Chapter
Portland

Sharon Morris
Health Care Administrator (ret.)
Grants Pass

Larry Mullins
President and CEO, Samaritan Health Services
Corvallis

Nicola Pinson
Director of Policy and Legal Counsel, Oregon Primary Care Association
Portland

Thomas Reardon, MD
Retired Physician
Gresham

Oregon Health Fund Board
Finance Committee
Members Appointed as of October 2, 2007

Richard (Andy) Anderson
Chief Financial Officer & Senior Vice President, Cascade Corporation
Portland

Kerry Barnett
Executive Vice President, The Regence Group
Chair, Oregon Health Policy Commission
Portland

Peter Bernardo, M.D.
Private Practice, General Surgery
Salem

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

Lynn-Marie Crider
Public Policy Director, Service Employees International Union (SEIU) Local 49
Portland

Jim Diegel
CEO and President, Cascade Healthcare
Bend

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

Cherry Harris
Labor Representative, International Union of Operating Engineers, Local 701
Gladstone/Oregon City

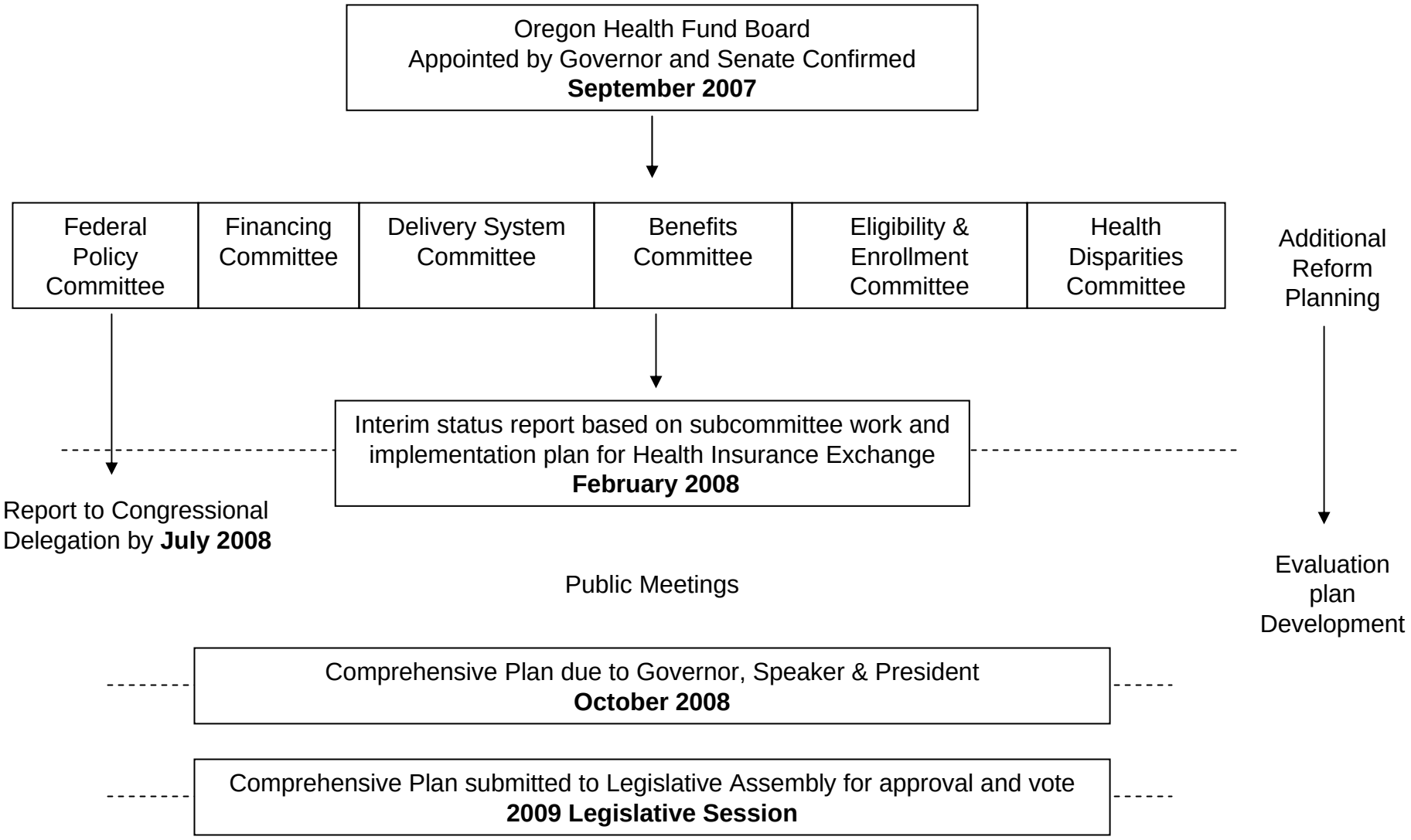
David Hooff
Vice President of Finance, Northwest Health Foundation
Portland

Denise Honzel
Former Director, OR Center for Health Professions, Oregon Institute of Technology
Member, Oregon Health Policy Commission
Portland

John Lee
Consultant, Strategic Affairs, Providence Health System
Portland

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

Timeline for Oregon Health Fund Board Reform 2007-2008



SB 329 Overview

Duties of Committees & the Office for Oregon Health Policy & Research (OHPR)

Financing Subcommittee
- Health Insurance Exchange (initial plan due Feb. 2008)
- Strategic Revenue Model
- Collection of employer/individual contributions
- Maximizing federal funds

Delivery Committee
- Efficient, effective, high-value delivery system model
- Information technology
- Consumer education
- Primary care revitalization and wellness
- Developing Quality Institute (along with OHPR)
- Streamlining current state health agencies/functions

Federal Policy Committee
- Medicaid waivers
- Federal tax code
- EMTALA Waivers
- Medicare policies

Eligibility & Enrollment Subcommittee
- Affordability
- Enrollment procedures
- Outreach
- Portability

Benefits Committee
- Benefit Package(s)
- Cost Sharing

OHPR
- Oregon Prescription Drug Plan Operation
- Evaluation Plan
- Current other duties include:
  - -Health Resources Commission
  - -OHREC
  - -Hospital financial, utilization, & quality data
  - - Uninsured data
  - - Long term care utilization
  - - Medicaid monitoring
  - -Data, research, and evaluation outside of health care reform

Health Disparities & Vulnerable Populations Committee
- Enrolling vulnerable populations
- Reducing disparities through delivery reform
- Benefit design to support vulnerable populations

Enrolled
Senate Bill 329

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Commission on Health Care Access and Affordability)

CHAPTER .....

AN ACT

Relating to the Oregon Health Fund program; creating new provisions; amending ORS 414.221, 414.312, 414.314, 414.316, 414.318, 414.320 and 442.011 and sections 2 and 3, chapter 314, Oregon Laws 2005; appropriating money; limiting expenditures; and declaring an emergency.

Whereas improving and protecting the health of Oregonians must be a primary issue and an important goal of the state; and

Whereas the objective of Oregon's health care system is health, not just the financing and delivery of health care services; and

Whereas health is more than just the absence of physical and mental disease, it is the product of a number of factors, only one of which is access to the medical system; and

Whereas persons with disabilities and other ongoing conditions can live long and healthy lives; and

Whereas Oregonians cannot achieve the objective of health unless all individuals have timely access to a defined set of essential health services; and

Whereas Oregonians cannot achieve the objective of health unless the state invests not only in health care, but also in education, economic opportunity, housing, sustainable environmental stewardship, full participation and other areas that are important contributing factors to health; and

Whereas the escalating cost of health care is compromising the ability to invest in those other areas that contribute to the health of the population; and

Whereas Oregon cannot achieve its objective of health unless Oregonians control costs in the health care system; and

Whereas Oregon cannot control costs unless Oregonians:

(1) Develop effective strategies through education of individuals and health care providers, development of policies and practices as well as financial incentives and disincentives to empower individuals to assume more personal responsibility for their own health status through the choices they make;

(2) Reevaluate the structure of Oregon's financing and eligibility system in light of the realities and circumstances of the 21st century and of what Oregonians want the system to achieve from the standpoint of a healthy population; and

(3) Rethink how Oregonians define a "benefit" and restructure the misaligned financial incentives and inefficient system through which health care is currently delivered; and

Whereas public resources are finite, and therefore the public resources available for health care are also finite; and

Whereas finite resources require that explicit priorities be set through an open process with public input on what should and should not be financed with public resources; and

Whereas those priorities must be based on publicly debated criteria that reflect a consensus of social values and that consider the good of individuals across their lifespans; and

Whereas those with more disposable private income will always be able to purchase more health care than those who depend solely on public resources; and

Whereas society is responsible for ensuring equitable financing for the defined set of essential health services for those Oregonians who cannot afford that care; and

Whereas health care policies should emphasize public health and encourage the use of quality services and evidence-based treatment that is appropriate and safe and that discourages unnecessary treatment; and

Whereas health care providers and informed patients must be the primary decision makers in the health care system; and

Whereas access, cost, transparency and quality are intertwined and must be simultaneously addressed for health care reform to be sustainable; and

Whereas health is the shared responsibility of individual consumers, government, employers, providers and health plans; and

Whereas individual consumers, government, employers, providers and health plans must be part of the solution and share in the responsibility for both the financing and delivery of health care; and

Whereas the current health care system is unsustainable in large part because of outdated federal policies that reflect the realities of the last century instead of the realities of today and that are based on assumptions that are no longer valid; and

Whereas the ability of states to maintain the public's health is increasingly constrained by those federal policies, which were built around "categories" rather than a commitment to ensure all citizens have timely access to essential health services; and

Whereas the economic and demographic environment in which state and federal policies were created has changed dramatically over the past 50 years, while the programs continue to reflect a set of circumstances that existed in the mid-20th century; and

Whereas any strategies for financing, mandating or developing new programs to expand access must address what will be covered with public resources and how those services will be delivered; otherwise, those strategies will do little to stem escalating medical costs, make health care more affordable or create a sustainable system; and

Whereas incremental changes will not solve Oregon's health care crisis and comprehensive reform is required; now, therefore,

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 to 13 of this 2007 Act shall be known and may be cited as the Healthy Oregon Act.

SECTION 2. As used in sections 2 to 13 of this 2007 Act, except as otherwise specifically provided or unless the context requires otherwise:

(1) "Accountable health plan" means a prepaid managed care health services organization described in ORS 414.725 or an entity that contracts with the Oregon Health Fund Board to provide a health benefit plan, as defined in ORS 743.730, through the Oregon Health Fund program.

(2) "Core health care safety net provider" means a safety net provider that is especially adept at serving persons who experience significant barriers to accessing health care, including homelessness, language and cultural barriers, geographic isolation, mental illness, lack of health insurance and financial barriers, and that has a mission or mandate to deliver services to persons who experience barriers to accessing care and serves a substantial share of persons without health insurance and persons who are enrolled in Medicaid or Medicare, as well as other vulnerable or special populations.

(3) "Defined set of essential health services" means the services:

(a) Identified by the Health Services Commission using the methodology in ORS 414.720 or an alternative methodology developed pursuant to section 9 (3)(c) of this 2007 Act; and

(b) Approved by the Oregon Health Fund Board.

(4) "Employer" has the meaning given that term in ORS 657.025.

(5) "Oregon Health Card" means the card issued by the Oregon Health Fund Board that verifies the eligibility of the holder to participate in the Oregon Health Fund program.

(6) "Oregon Health Fund" means the fund established in section 8 of this 2007 Act.

(7) "Oregon Health Fund Board" means the board established in section 5 of this 2007 Act.

(8) "Safety net provider" means providers that deliver health services to persons experiencing cultural, linguistic, geographic, financial or other barriers to accessing appropriate, timely, affordable and continuous health care services. "Safety net providers" includes health care safety net providers, core health care safety net providers, tribal and federal health care organizations and local nonprofit organizations, government agencies, hospitals and individual providers.

SECTION 3. The Oregon Health Fund program shall be based on the following principles:

(1) Expanding access. The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.

(2) Equity. All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.

(3) Financing of the health care system must be equitable, broadly based and affordable.

(4) Population benefit. The public must set priorities to optimize the health of Oregonians.

(5) Responsibility for optimizing health must be shared by individuals, employers, health care systems and communities.

(6) Education is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.

(7) Effectiveness. The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.

(8) Efficiency. The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.

(9) Explicit decision-making. Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.

(10) Transparency. The evidence used to support decisions must be clear, understandable and observable to the public.

(11) Economic sustainability. Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.

(12) Aligned financial incentives. Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.

(13) Wellness. Health and wellness promotion efforts must be emphasized and strengthened.

(14) Community-based. The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.

(15) Coordination. Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.

(16) The health care safety net is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

SECTION 4. The intent of the Healthy Oregon Act is to develop an Oregon Health Fund program comprehensive plan, based upon the principles set forth in section 3 of this 2007 Act, that meets the intended goals of the program to:

(1) As a primary goal, cover the current uninsured population in Oregon through the expansion of the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program;

(2) Reform the health care delivery system to maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care;

(3) Ensure that all Oregonians have timely access to and participate in a health benefit plan that provides high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost;

(4) Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment;

(5) Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services;

(6) Allow for a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market;

(7) Use proven models of health care benefits, service delivery and payments that control costs and overutilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home;

(8) Provide services for dignified end-of-life care;

(9) Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers;

(10) Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money;

(11) Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured; and

(12) Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 5. (1) There is established within the Department of Human Services the Oregon Health Fund Board that shall be responsible for developing the Oregon Health Fund program comprehensive plan. The board shall consist of seven members appointed by the Governor, subject to confirmation by the Senate pursuant to section 4, Article III of the Oregon Constitution. The members of the board shall be selected based upon their ability to represent the best interests of Oregon as a whole. Members of the board shall have expertise, knowledge and experience in the areas of consumer advocacy, management, finance, labor and health care, and to the extent possible shall represent the geographic and ethnic diversity of the state. A majority of the board members must consist of individuals who do not receive or have not received within the past two years more than 50 percent of the individual's income or the income of the individual's family from the health care industry or the health insurance industry.

(2) Each board member shall serve for a term of four years. However, a board member shall serve until a successor has been appointed and qualified. A member is eligible for reappointment.

(3) If there is a vacancy for any cause, the Governor shall make an appointment to become effective immediately for the balance of the unexpired term.

(4) The board shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the board determines.

(5) A majority of the members of the board constitutes a quorum for the transaction of business.

(6) Official action by the board requires the approval of a majority of the members of the board.

(7) A member of the board is not entitled to compensation for services as a member, but is entitled to expenses as provided in ORS 292.495 (2).

SECTION 6. (1) Within 30 days after the effective date of this 2007 Act, the Governor shall appoint an executive director of the Oregon Health Fund Board who will be responsible for establishing the administrative framework for the board.

(2) The executive director appointed under this section may employ and shall fix the duties and amounts of compensation of persons necessary to carry out the provisions of sections 2 to 13 of this 2007 Act. Those persons shall serve at the pleasure of the executive director.

(3) The executive director shall serve at the pleasure of the Governor.

SECTION 7. Except as otherwise provided by law, and except for ORS 279A.250 to 279A.290, the provisions of ORS chapters 279A, 279B and 279C do not apply to the Oregon Health Fund Board.

SECTION 8. (1) The Oregon Health Fund is established separate and distinct from the General Fund. Interest earned from the investment of moneys in the Oregon Health Fund shall be credited to the fund. The Oregon Health Fund may include:

(a) Employer and employee health care contributions.

(b) Individual health care premium contributions.

(c) Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund, excluding Title XIX funds for long term care supports, services and administration, and reimbursements for graduate medical education costs pursuant to 42 U.S.C. 1395ww(h) and disproportionate share adjustments made pursuant to 42 U.S.C. 1396a(a)(13)(A)(iv).

(d) Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Health Fund program.

(e) Moneys appropriated to the Oregon Health Fund Board by the Legislative Assembly for carrying out the provisions of the Healthy Oregon Act.

(f) Interest earnings from the investment of moneys in the fund.

(g) Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Healthy Oregon Act.

(2)(a) All moneys in the Oregon Health Fund are continuously appropriated to the Oregon Health Fund Board to carry out the provisions of the Healthy Oregon Act.

(b) The Oregon Health Fund shall be segregated into subaccounts as required by federal law.

SECTION 9. (1)(a) The Oregon Health Fund Board shall establish a committee to examine the impact of federal law requirements on reducing the number of Oregonians without health insurance, improving Oregonians' access to health care and achieving the goals of the Healthy Oregon Act, focusing particularly on barriers to reducing the number of uninsured Oregonians, including but not limited to:

(A) Medicaid requirements such as eligibility categories and household income limits;

(B) Federal tax code policies regarding the impact on accessing health insurance or self-insurance and the affect on the portability of health insurance;

(C) Emergency Medical Treatment and Active Labor Act regulations that make the delivery of health care more costly and less efficient; and

(D) Medicare policies that result in Oregon's health care providers receiving significantly less than the national average Medicare reimbursement rate. The committee shall survey providers and determine how this and other Medicare policies and procedures affect costs, quality and access. The committee shall assess how an increase in Medicare reimbursement rates to Oregon providers would benefit Oregon in health care costs, quality and access to services, including improved access for persons with disabilities and improved access to long term care.

(b) With the approval of the Oregon Health Fund Board, the committee shall report its findings to the Oregon congressional delegation no later than July 31, 2008.

(c) The committee shall request that the Oregon congressional delegation:

(A) Participate in at least one hearing in each congressional district in this state on the impacts of federal policies on health care services; and

(B) Request congressional hearings in Washington, D.C.

(2) The Oregon Health Fund Board shall develop a comprehensive plan to achieve the Oregon Health Fund program goals listed in section 4 of this 2007 Act. The board shall establish subcommittees, organized to maximize efficiency and effectiveness and assisted, in the manner the board deems appropriate, by the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee, to develop proposals for the Oregon Health Fund program comprehensive plan. The proposals may address, but are not limited to, the following:

(a) Financing the Oregon Health Fund program, including but not limited to proposals for:

(A) A model for rate setting that ensures providers will receive fair and adequate compensation for health care services.

(B) Collecting employer and employee contributions and individual health care premium contributions, and redirecting them to the Oregon Health Fund.

(C) Implementing a health insurance exchange to serve as a central forum for uninsured individuals and businesses to purchase affordable health insurance.

(D) Taking best advantage of health savings accounts and similar vehicles for making health insurance more accessible to uninsured individuals.

(E) Addressing the issue of medical liability and medical errors including, but not limited to, consideration of a patients' compensation fund.

(F) Requesting federal waivers under Titles XIX and XXI of the Social Security Act, or other federal matching funds that may be made available to implement the comprehensive plan and increase access to health care.

(G) Evaluating statutory and regulatory barriers to the provision of cost-effective services, including limitations on access to information that would enable providers to fairly evaluate contract reimbursement, the regulatory effectiveness of the certificate of need process, consideration of a statewide uniform credentialing process and the costs and benefits of improving the transparency of costs of hospital services and health benefit plans.

(b) Delivering health services in the Oregon Health Fund program, including but not limited to proposals for:

(A) An efficient and effective delivery system model that ensures the continued viability of existing prepaid managed care health services organizations, as described in ORS 414.725, to serve Medicaid populations.

(B) The design and implementation of a program to create a public partnership with accountable health plans to provide, through the use of an Oregon Health Card, health insur-

ance coverage of the defined set of essential health services that meets standards of affordability based upon a calculation of how much individuals and families, particularly the uninsured, can be expected to spend for health insurance and still afford to pay for housing, food and other necessities. The proposal must ensure that each accountable health plan:

(i) Does not deny enrollment to qualified Oregonians eligible for Medicaid;

(ii) Provides coverage of the entire defined set of essential health services;

(iii) Will develop an information system to provide written information, and telephone and Internet access to information, necessary to connect enrollees with appropriate medical and dental services and health care advice;

(iv) Offers a simple and timely complaint process;

(v) Provides enrollees with information about the cost and quality of services offered by health plans and procedures offered by medical and dental providers;

(vi) Provides advance disclosure of the estimated out-of-pocket costs of a service or procedure;

(vii) Has contracts with a sufficient network of providers, including but not limited to hospitals and physicians, with the capacity to provide culturally appropriate, timely health services and that operate during hours that allow optimal access to health services;

(viii) Ensures that all enrollees have a primary care medical home;

(ix) Includes in its network safety net providers and local community collaboratives;

(x) Regularly evaluates its services, surveys patients and conducts other assessments to ensure patient satisfaction;

(xi) Has strategies to encourage enrollees to utilize preventive services and engage in healthy behaviors;

(xii) Has simple and uniform procedures for enrollees to report claims and for accountable health plans to make payments to enrollees and providers;

(xiii) Provides enrollment, encounter and outcome data for evaluation and monitoring purposes; and

(xiv) Meets established standards for loss ratios, rating structures and profit or nonprofit status.

(C) Using information technology that is cost-neutral or has a positive return on investment to deliver efficient, safe and quality health care and a voluntary program to provide every Oregonian with a personal electronic health record that is within the individual's control, use and access and that is portable.

(D) Empowering individuals through education as well as financial incentives to assume more personal responsibility for their own health status through the choices they make.

(E) Establishing and maintaining a registry of advance directives and Physician Orders for Life-Sustaining Treatment (POLST) forms and a process for assisting a person who chooses to execute an advance directive in accordance with ORS 127.531 or a POLST form.

(F) Designing a system for regional health delivery.

(G) Combining, reorganizing or eliminating state agencies involved in health planning and policy, health insurance and the delivery of health care services and integrating and streamlining their functions and programs to maximize their effectiveness and efficiency. The subcommittee may consider, but is not limited to considering, the following state agencies, functions or programs:

(i) The Health Services Commission;

(ii) The Oregon Health Policy Commission;

(iii) The Health Resources Commission;

(iv) The Medicaid Advisory Committee;

(v) The Department of Human Services, including but not limited to the state Medicaid agency, the Office for Oregon Health Policy and Research, offices involved in health systems planning, offices involved in carrying out the duties of the department with respect to cer-

tificates of need under ORS 443.305 to 443.350 and the functions of the department under ORS chapter 430;

(vi) The Department of Consumer and Business Services;

(vii) The Oregon Patient Safety Commission;

(viii) The Office of Private Health Partnerships;

(ix) The Public Employees' Benefit Board;

(x) The State Accident Insurance Fund Corporation; and

(xi) The Office of Rural Health.

(c) Establishing the defined set of essential health services, including but not limited to proposals for a methodology, consistent with the principles in section 3 of this 2007 Act, for determining and continually updating the defined set of essential health services. The Oregon Health Fund Board may delegate this function to the Health Services Commission established under ORS 414.715.

(d) The eligibility requirements and enrollment procedures for the Oregon Health Fund program, including, but not limited to, proposals for:

(A) Public subsidies of premiums or other costs under the program.

(B) Streamlined enrollment procedures, including:

(i) A standardized application process;

(ii) Requirements to ensure that enrollees demonstrate Oregon residency;

(iii) A process to enable a provider to enroll an individual in the Oregon Health Fund program at the time the individual presents for treatment to ensure coverage as of the date of the treatment; and

(iv) Permissible waiting periods, preexisting condition limitations or other administrative requirements for enrollment.

(C) A grievance and appeal process for enrollees.

(D) Standards for disenrollment and changing enrollment in accountable health plans.

(E) An outreach plan to educate the general public, particularly uninsured and underinsured persons, about the program and the program's eligibility requirements and enrollment procedures.

(F) Allowing employers to offer health insurance coverage by insurers of the employer's choice or to contract for coverage of benefits beyond the defined set of essential health services.

(3) On the effective date of this 2007 Act, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee are directed to begin compiling data and conducting research to inform the decision-making of the subcommittees when they are convened. No later than February 1, 2008, the Oregon Health Policy Commission, the Office for Oregon Health Policy and Research, the Health Services Commission and the Medicaid Advisory Committee shall present reports containing data and recommendations to the subcommittees as follows:

(a) The Oregon Health Policy Commission shall report on the financing mechanism for the comprehensive plan;

(b) The Administrator of the Office for Oregon Health Policy and Research shall report on the health care delivery model of the comprehensive plan;

(c) The Health Services Commission shall report on the methodology for establishing the defined set of essential health services under the comprehensive plan; and

(d) The Medicaid Advisory Committee shall report on eligibility and enrollment requirements under the comprehensive plan.

(4) The membership of the subcommittees shall, to the extent possible, represent the geographic and ethnic diversity of the state and include individuals with actuarial and financial management experience, individuals who are providers of health care, including safety net providers, and individuals who are consumers of health care, including seniors, persons with disabilities and individuals with complex medical needs.

(5) Each subcommittee shall select one of its members as chairperson for such terms and with such duties and powers necessary for performance of the functions of those offices. Each chairperson shall serve as an ex officio member of the Oregon Health Fund Board. Chairpersons shall collaborate to integrate the committee recommendations to the extent possible.

(6) The committee and the subcommittees are public bodies for purposes of ORS chapter 192 and must provide reasonable opportunity for public testimony at each meeting.

(7) All agencies of state government, as defined in ORS 174.111, are directed to assist the committee, the subcommittees and the Oregon Health Fund Board in the performance of their duties and, to the extent permitted by laws relating to confidentiality, to furnish such information and advice as the members of the committees, the subcommittees and the Oregon Health Fund Board consider necessary to perform their duties.

(8) The Oregon Health Fund Board shall report to the Legislative Assembly not later than February 29, 2008. The report must describe the progress of the subcommittees and the board toward developing a comprehensive plan to:

(a) Decrease the number of children and adults without health insurance;

(b) Ensure universal access to health care;

(c) Contain health care costs; and

(d) Address issues regarding the quality of health care services.

(9) The Oregon Health Fund Board shall present a plan to the Legislative Assembly not later than February 1, 2008, for the design and implementation of the health insurance exchange described in subsection (2)(a)(C) of this section.

SECTION 10. The Oregon Health Fund Board shall conduct public hearings on the draft Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act and solicit testimony and input from advocates representing seniors, persons with disabilities, tribes, consumers of mental health services, low-income Oregonians, employers, employees, insurers, health plans and providers of health care including, but not limited to, physicians, dentists, oral surgeons, chiropractors, naturopaths, hospitals, clinics, pharmacists, nurses and allied health professionals.

SECTION 11. (1) The Oregon Health Fund Board shall finalize the Oregon Health Fund program comprehensive plan developed under section 9 of this 2007 Act with due consideration to the information provided in the public hearings under section 10 of this 2007 Act and shall present the finalized comprehensive plan to the Governor, the Speaker of the House of Representatives and the President of the Senate no later than October 1, 2008. The board is authorized to submit the finalized comprehensive plan as a measure request directly to the Legislative Counsel upon the convening of the Seventy-fifth Legislative Assembly.

(2) Upon legislative approval of the comprehensive plan, the board is authorized to request federal waivers deemed necessary and appropriate to implement the comprehensive plan.

(3) Upon legislative approval of the comprehensive plan, the board is authorized immediately to implement any elements necessary to implement the plan that do not require legislative changes or federal approval.

SECTION 12. (1) The Oregon Health Fund program comprehensive plan described in section 11 of this 2007 Act must ensure, except as provided in subsection (2) of this section, that a resident of Oregon who is not a beneficiary of a health benefit plan providing coverage of the defined set of essential health services and who is not eligible to be enrolled in a publicly funded medical assistance program providing primary care and hospital services participates in the Oregon Health Fund program. A resident of Oregon who is a beneficiary of a health benefit plan or enrolled in a medical assistance program described in this subsection may choose to participate in the program. An employee of an employer located in this state may participate in the program if Oregon is the location of the employee's physical worksite, regardless of the employee's state of residence.

(2) Oregon residents who are enrolled in commercial health insurance plans, self-insured programs, health plans funded by a Taft-Hartley trust, or state or local government health insurance pools may not be required to participate in the Oregon Health Fund Program.

SECTION 13. (1) The Administrator of the Office for Oregon Health Policy and Research, in collaboration with the Oregon Health Research and Evaluation Collaborative and other persons with relevant expertise, shall be responsible for developing a plan for evaluating the implementation and outcomes of the legislation described in section 11 of this 2007 Act. The evaluation plan shall focus particularly on the individuals receiving health care covered through the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program and shall include measures of:

(a) Access to care;

(b) Access to health insurance coverage;

(c) Quality of care;

(d) Consumer satisfaction;

(e) Health status;

(f) Provider capacity;

(g) Population demand;

(h) Provider and consumer participation;

(i) Utilization patterns;

(j) Health outcomes;

(k) Health disparities;

(L) Financial impacts, including impacts on medical debt;

(m) The extent to which employers discontinue coverage due to the availability of publicly financed coverage or other employer responses;

(n) Impacts on the financing of health care and uncompensated care;

(o) Adverse selection, including migration to Oregon primarily for access to health care;

(p) Use of technology;

(q) Transparency of costs; and

(r) Impact on health care costs.

(2) The administrator shall develop recommendations for a model quality institute that shall:

(a) Develop and promote methods for improving collection, measurement and reporting of information on quality in health care;

(b) Provide leadership and support to further the development of widespread and shared electronic health records;

(c) Develop the capacity of the workforce to capitalize on health information technology;

(d) Encourage purchasers, providers and state agencies to improve system transparency and public understanding of quality in health care;

(e) Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and

(f) Coordinate an effort among all state purchasers of health care and insurers to support delivery models and reimbursement strategies that will more effectively support infrastructure investments, integrated care and improved health outcomes.

SECTION 14. ORS 442.011 is amended to read:

442.011. (1) There is created in the [*Oregon Department of Administrative Services*] **Department of Human Services** the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the

Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission **and the Oregon Health Fund Board**.

SECTION 15. ORS 442.011, as amended by section 14 of this 2007 Act, is amended to read:

442.011. (1) There is created in the Department of Human Services the Office for Oregon Health Policy and Research. The Administrator of the Office for Oregon Health Policy and Research shall be appointed by the Governor and the appointment shall be subject to Senate confirmation in the manner prescribed in ORS 171.562 and 171.565. The administrator shall be an individual with demonstrated proficiency in planning and managing programs with complex public policy and fiscal aspects such as those involved in the Oregon Health Plan. Before making the appointment, the Governor must advise the President of the Senate and the Speaker of the House of Representatives of the names of at least three finalists and shall consider their recommendation in appointing the administrator.

(2) In carrying out the responsibilities and duties of the administrator, the administrator shall consult with and be advised by the Oregon Health Policy Commission [*and the Oregon Health Fund Board*].

SECTION 16. ORS 414.221 is amended to read:

414.221. The Medicaid Advisory Committee shall advise the Administrator of the Office for Oregon Health Policy and Research and the [*Department*] **Director** of Human Services on:

(1) Medical care, including mental health and alcohol and drug treatment and remedial care to be provided under ORS chapter 414; and

(2) The operation and administration of programs provided under ORS chapter 414.

SECTION 17. ORS 414.312, as amended by section 1, chapter 2, Oregon Laws 2007 (Ballot Measure 44 (2006)), is amended to read:

414.312. (1) As used in ORS 414.312 to 414.318:

(a) "Pharmacy benefit manager" means an entity that, in addition to being a prescription drug claims processor, negotiates and executes contracts with pharmacies, manages preferred drug lists, negotiates rebates with prescription drug manufacturers and serves as an intermediary between the Oregon Prescription Drug Program, prescription drug manufacturers and pharmacies.

(b) "Prescription drug claims processor" means an entity that processes and pays prescription drug claims, adjudicates pharmacy claims, transmits prescription drug prices and claims data between pharmacies and the Oregon Prescription Drug Program and processes related payments to pharmacies.

(c) "Program price" means the reimbursement rates and prescription drug prices established by the administrator of the Oregon Prescription Drug Program.

(2) The Oregon Prescription Drug Program is established in the [*Oregon Department of Administrative Services*] **Department of Human Services**. The purpose of the program is to:

(a) Purchase prescription drugs or reimburse pharmacies for prescription drugs in order to receive discounted prices and rebates;

(b) Make prescription drugs available at the lowest possible cost to participants in the program; and

(c) Maintain a list of prescription drugs recommended as the most effective prescription drugs available at the best possible prices.

(3) The Director of [*the Oregon Department of Administrative Services*] **Human Services** shall appoint an administrator of the Oregon Prescription Drug Program. The administrator shall:

(a) Negotiate price discounts and rebates on prescription drugs with prescription drug manufacturers;

(b) Purchase prescription drugs on behalf of individuals and entities that participate in the program;

(c) Contract with a prescription drug claims processor to adjudicate pharmacy claims and transmit program prices to pharmacies;

(d) Determine program prices and reimburse pharmacies for prescription drugs;

(e) Adopt and implement a preferred drug list for the program;

(f) Develop a system for allocating and distributing the operational costs of the program and any rebates obtained to participants of the program; and

(g) Cooperate with other states or regional consortia in the bulk purchase of prescription drugs.

(4) The following individuals or entities may participate in the program:

(a) Public Employees' Benefit Board;

(b) Local governments as defined in ORS 174.116 and special government bodies as defined in ORS 174.117 that directly or indirectly purchase prescription drugs;

(c) Enrollees in the Senior Prescription Drug Assistance Program created under ORS 414.342;

(d) Oregon Health and Science University established under ORS 353.020;

(e) State agencies that directly or indirectly purchase prescription drugs, including agencies that dispense prescription drugs directly to persons in state-operated facilities; and

(f) Residents of this state who do not have prescription drug coverage.

(5) The state agency that receives federal Medicaid funds and is responsible for implementing the state's medical assistance program may not participate in the program.

(6) The administrator may establish different reimbursement rates or prescription drug prices for pharmacies in rural areas to maintain statewide access to the program.

(7) The administrator shall establish the terms and conditions for a pharmacy to enroll in the program. A licensed pharmacy that is willing to accept the terms and conditions established by the administrator may apply to enroll in the program.

(8) Except as provided in subsection (9) of this section, the administrator may not:

(a) Contract with a pharmacy benefit manager;

(b) Establish a state-managed wholesale or retail drug distribution or dispensing system; or

(c) Require pharmacies to maintain or allocate separate inventories for prescription drugs dispensed through the program.

(9) The administrator shall contract with one or more entities to provide the functions of a prescription drug claims processor. The administrator may also contract with a pharmacy benefit manager to negotiate with prescription drug manufacturers on behalf of the administrator.

(10) Notwithstanding subsection (4)(f) of this section, individuals who are eligible for Medicare Part D prescription drug coverage may participate in the program.

SECTION 18. ORS 414.314 is amended to read:

414.314. (1) An individual or entity described in ORS 414.312 (4) may apply to participate in the Oregon Prescription Drug Program. Participants shall apply annually on an application provided by the [*Oregon Department of Administrative Services*] **Department of Human Services**. The department may charge participants a nominal fee to participate in the program. The department shall issue a prescription drug identification card annually to participants of the program.

(2) The department shall provide a mechanism to calculate and transmit the program prices for prescription drugs to a pharmacy. The pharmacy shall charge the participant the program price for a prescription drug.

(3) A pharmacy may charge the participant the professional dispensing fee set by the department.

(4) Prescription drug identification cards issued under this section must contain the information necessary for proper claims adjudication or transmission of price data.

SECTION 19. ORS 414.316 is amended to read:

414.316. The Office for Oregon Health Policy and Research shall develop and recommend to the [*Oregon Department of Administrative Services*] **Department of Human Services** a preferred drug list that identifies preferred choices of prescription drugs within therapeutic classes for particular diseases and conditions, including generic alternatives, for use in the Oregon Prescription Drug

Program. The office shall conduct public hearings and use evidence-based evaluations on the effectiveness of similar prescription drugs to develop the preferred drug list.

SECTION 20. ORS 414.318 is amended to read:

414.318. The Prescription Drug Purchasing Fund is established separate and distinct from the General Fund. The Prescription Drug Purchasing Fund shall consist of moneys appropriated to the fund by the Legislative Assembly and moneys received by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the purposes established in this section in the form of gifts, grants, bequests, endowments or donations. The moneys in the Prescription Drug Purchasing Fund are continuously appropriated to the [*Oregon Department of Administrative Services*] **department** and shall be used to purchase prescription drugs, reimburse pharmacies for prescription drugs and reimburse the department for the costs of administering the Oregon Prescription Drug Program, including contracted services costs, computer costs, professional dispensing fees paid to retail pharmacies and other reasonable program costs. Interest earned on the fund shall be credited to the fund.

SECTION 21. ORS 414.320 is amended to read:

414.320. The [*Oregon Department of Administrative Services*] **Department of Human Services** shall adopt rules to implement and administer ORS 414.312 to 414.318. The rules shall include but are not limited to establishing procedures for:

(1) Issuing prescription drug identification cards to individuals and entities that participate in the Oregon Prescription Drug Program; and

(2) Enrolling pharmacies in the program.

SECTION 22. Section 2, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 2. In addition to the notices required under ORS 183.335 (15), the [*Oregon Department of Administrative Services*] **Department of Human Services** shall give notice to the individual members of any interim or session committee with authority over the subject matter of the rule if the department proposes to adopt a rule under ORS 414.320.

SECTION 23. Section 3, chapter 314, Oregon Laws 2005, is amended to read:

Sec. 3. Section 2**, chapter 314, Oregon Laws 2005,** [*of this 2005 Act*] applies to rules adopted by the [*Oregon Department of Administrative Services*] **Department of Human Services** for the Oregon Prescription Drug Program on or after [*the effective date of this 2005 Act*] **June 28, 2005**.

SECTION 24. (1) There is appropriated to the Oregon Health Fund Board, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $1 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, but excluding lottery funds and federal funds, collected or received by the Oregon Health Fund Board.

SECTION 25. (1) There is appropriated to the Department of Human Services, for the biennium beginning July 1, 2007, out of the General Fund, the amount of $1,215,350 for the purpose of carrying out the provisions of sections 2 to 13 of this 2007 Act.

(2) Notwithstanding any other law limiting expenditures, the amount of $671,971 is established for the biennium beginning July 1, 2007, as the maximum limit for payment of expenses from federal funds collected or received by the Department of Human Services, for the purpose of carrying out sections 2 to 13 of this 2007 Act.

SECTION 26. (1) The unexpended balances of amounts authorized to be expended by the Oregon Department of Administrative Services for the biennium beginning July 1, 2007, from revenues dedicated, continuously appropriated, appropriated or otherwise made available for the purpose of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act are transferred to and are available for expenditure by the Department of Human Services, for the purposes of administering and enforcing the duties, functions and powers transferred by the amendments to statutes and session laws by sections 14 and 16 to 23 of this 2007 Act.

(2) The expenditure classifications, if any, established by Acts authorizing or limiting expenditures by the Oregon Department of Administrative Services remain applicable to expenditures by the Department of Human Services under this section.

SECTION 27. Sections 1 to 13 of this 2007 Act are repealed on January 2, 2010.

SECTION 28. The amendments to ORS 442.011 by section 15 of this 2007 Act become operative on January 2, 2010.

SECTION 29. This 2007 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2007 Act takes effect on its passage.

Passed by Senate June 20, 2007

.....
Secretary of Senate

.....
President of Senate

Passed by House June 22, 2007

.....
Speaker of House

Received by Governor:

.....M.,....., 2007

Approved:

.....M.,....., 2007

.....
Governor

Filed in Office of Secretary of State:

.....M.,....., 2007

.....
Secretary of State

Summary of SB 329

<u>Section 1</u> – Names provisions of SB 329 the "Healthy Oregon Act"

<u>Section 2</u> – Definitions

<u>Section 3</u> - Principles

Oregon Health Fund program is based on 16 principles:

Principle		Description
1	Expanding access	The state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program must be expanded to include the current uninsured population in Oregon to the greatest extent possible.
2	Equity	All individuals must be eligible for and have timely access to at least the same set of essential and effective health services.
3	Financing	…of the health care system must be equitable, broadly based and affordable.
4	Population benefit	The public must set priorities to optimize the health of Oregonians.
5	Responsibility	…for optimizing health must be shared by individuals, employers, health care systems and communities.
6	Education	…is a powerful tool for health promotion. The health care system, health plans, providers and government must promote and engage in education activities for individuals, communities and providers.
7	Effectiveness	The relationship between specific health interventions and their desired health outcomes must be backed by unbiased, objective medical evidence.
8	Efficiency	The administration and delivery of health services must use the fewest resources necessary to produce the most effective health outcome.
9	Explicit decision-making	Decision-making will be clearly defined and accessible to the public, including lines of accountability, opportunities for public engagement and how public input will be used in decision-making.
10	Transparency	The evidence used to support decisions must be clear, understandable and observable to the public.
11	Economic sustainability	Health service expenditures must be managed to ensure long-term sustainability, using efficient planning, budgeting and coordination of resources and reserves, based on public values and recognizing the impact that public and private health expenditures have on each other.
12	Aligned financial incentives	Financial incentives must be aligned to support and invest in activities that will achieve the goals of the Oregon Health Fund program.
13	Wellness	Health and wellness promotion efforts must be emphasized and strengthened.
14	Community-based	The delivery of care and distribution of resources must be organized to take place at the community level to meet the needs of the local population, unless outcomes or cost can be improved at regional or statewide levels.
15	Coordination	Collaboration, coordination and integration of care and resources must be emphasized throughout the health care system.
16	The health care safety net	…is a key delivery system element for the protection of the health of Oregonians and the delivery of community-based care.

Section 4 - Goals

The Oregon Health Fund program will develop a comprehensive plan that meets these 12 goals:

Goal		Means
1	Cover the current uninsured in Oregon	Expand the state Medicaid program, the Oregon State Children's Health Insurance Program and the Family Health Insurance Assistance Program.
2	Reform the health care delivery system	Maximize federal and other public resources without compromising proven programs supported by federal law that ensure to vulnerable populations access to efficient and high quality care.
3	Give Oregonians timely access to a health benefit plan	Ensure access to and participation in health benefit plans that provide high quality, effective, safe, patient-centered, evidence-based and affordable health care delivered at the lowest cost.
4	Finance coverage of essential health services	Develop a method to finance the coverage of a defined set of essential health services for Oregonians that is not necessarily tied directly to employment.
5	Encourage participation	Allow the potential for employees, employers, individuals and unions to participate in the program, or to purchase primary coverage or offer, purchase or bargain for coverage of benefits beyond the defined set of essential health services.
6	Encourage public and private health care partnerships	Allow a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the health care market.
7	Control costs and over-utilization, encourage care management	Use proven models of health care benefits, service delivery and payments that control costs and over utilization, with emphasis on preventive care and chronic disease management using evidence-based outcomes and a health benefit model that promotes a primary care medical home.
8	Improve end-of-life care	Provide services for dignified end-of-life care.
9	Change payment structure	Restructure the health care system so that payments for services are fair and proportionate among various populations, health care programs and providers.
10	Establish high quality, transparent health care delivery	Fund a high quality and transparent health care delivery system that will be held to high standards of transparency and accountability and allows users and purchasers to know what they are receiving for their money.
11	Make funding equitable and affordable	Ensure that funding for health care is equitable and affordable for all Oregon residents, especially the uninsured
12	Try to limit inflation to cost of living	Ensure, to the greatest extent possible, that annual inflation in the cost of providing access to essential health care services does not exceed the increase in the cost of living for the previous calendar year, based on the Portland-Salem, OR-WA, Consumer Price Index. for All Urban Consumers for All Items, as published by the Bureau of Labor Statistics of the United States Department of Labor.

Oregon Health Fund Board (Sections 5-12)

Section 5 – Board Location within State Government

The Board is established within the Department of Human Services (DHS).

Section 5 – Board Membership

Seven members appointed by the Governor and confirmed by the Senate.

Members need:

- Ability to represent the best interests of Oregon as a whole
- Expertise, knowledge and experience in consumer advocacy, management, finance, labor, health care
- Represent geographic and ethnic diversity of Oregon
- Majority of Board (4) not recently and significantly associated with health care industry or health insurance industry.
- Four (4) year term of appointment
  - Serve until successor is appointed
  - Eligible for reappointment (no limit in statute)
- Immediate appointment by Governor for vacancy for balance of unexpired term
- Board selects Chairperson and Vice Chairperson
  - Terms, duties and powers determined by Board (i.e., bylaws)
- Majority (4) constitutes quorum for transaction of business
- Official action by Board requires approval of a majority (4)
- Not entitled to compensation, but entitled to expenses [ORS 292.495(2)]

Section 5 – Responsibility

Board will develop the Oregon Health Fund program comprehensive plan.

Section 6 – Executive Director

Executive Director of the Oregon Health Fund Board serves at the pleasure of the Governor.

Section 7 – Purchasing Rules

The Board is generally exempt from public contracting statutes.

Section 8 – Fund's Administration and Organization

The Oregon Health Fund is established separate from the General Fund. The funds may include:

- Employer and employee health care contributions
- Individual health care premium contributions
- Federal funds
- US Government contributions
- Money appropriated by the Legislature
- Interest
- Gifts, grants, contributions

Section 9 – Board Committees and Subcommittees

(1) Committee to examine impact of federal law

- Full Board approves report

- Committee is public body (ORS chapter 192) and must provide for public testimony
- Report sent to Oregon congressional delegation no later than Jul 31, 2008
- Request delegation hold
  - One hearing in Oregon
  - Congressional hearings in Washington, D.C.

(2) Subcommittees to develop proposals for Board's comprehensive plan
- Assisted by Health Policy Commission, OHPR, Health Services Commission and Medicaid Advisory Committee
- Subcommittees will include persons other than Board members
  - Include individuals with actuarial and financial management experience, health care providers, consumers of health care
- Subcommittees are public bodies (ORS chapter 192) and must provide for public testimony
- Subcommittees select chairperson and determine term and duties
  - Subcommittee chairpersons serve as ex-officio members of Board

Subcommittee proposals for reform comprehensive plan to Board
- Financing Oregon Health Fund program (report due from OHPC to Board by 2/1/08). Provide recommendations on:
  - Model for rate setting
  - Collecting employer, employee and individual health care premium contributions
  - Implementing health insurance exchange
  - Utilizing vehicles for making insurance more accessible to the uninsured
  - Addressing medical liability and medical errors
  - Requesting federal waivers as needed
  - Evaluating statutory and regulatory barriers to the provision of cost-effective services

- Delivering health services in the Oregon Health Fund program (report due from OHPR to Board by 2/1/08). Provide recommendations on:
  - Delivering health services in the Oregon Health Fund program
  - An efficient and effective delivery system model
  - Design and implementation of public partnership with AHPs to provide coverage of defined set of essential health services
  - Using information technology
  - Education and incentives to encourage increased personal responsibility for health
  - Establishing and maintaining a registry of advance directives and POLST forms
  - Combining, reorganizing or eliminating state agencies to maximize effectiveness and efficiency

- Establishing the defined set of essential health services (report due from the Health Services Committee to Board by 2/1/08).

- Eligibility requirements and enrollment procedures (report due from Medicaid Advisory Committee to Board by 2/1/08). Recommendation topics include:
  - Public subsidies
  - Streamlined enrollment procedures
  - Grievance and appeal process

- Standards for disenrollment and changing enrollment in AHPs
- Outreach plan regarding the program, eligibility requirements and enrollment procedure
- Allowing employers to offer insurance of employer's choice and to contract for coverage beyond the defined set of essential health services

Subcommittee Structure

- Membership should represent Oregon's diversity and include individuals with actuarial and financial management experience, health care providers, persons with disabilities and individuals with complex medical needs.
- Subcommittee chairs serve as ex officio members of Oregon Health Fund Board.
- Committee, subcommittees are public bodies and must provide opportunity for public testimony.
- All agencies of state government are directed to assist the committee, subcommittees and Board.

<u>Section 10</u> – Board reports to Legislature

- The Board reports to the Legislature on the design and implementation of a health insurance exchange. The report is due by February 1, 2008.

- The Board reports to the Legislature by Feb 29, 2008 describing the progress of subcommittees and Board in developing a comprehensive plan to:
  - Decrease number of children and adults without health insurance
  - Ensure universal access to health care
  - Contain health care costs
  - Address issues of quality of health care services

<u>Section 11</u> – Finalizing the comprehensive plan

- The Board will present the finalized comprehensive plan to the Governor, House Speaker and Senate President by October 1, 2008.
- The plan can be submitted as a measure request to the Legislative Counsel at the start of 75th Legislative Assembly.

<u>Section 12</u> – Authority for Ensuring Participation

- The Oregon Health Fund program has responsibility for ensuring that Oregon residents participate in the Oregon Health Fund program
- The following individuals are exempted from mandatory enrollment in the Oregon Health Fund program and may enroll voluntarily if they choose:
  - An Oregon resident who is a beneficiary of a health benefit plan providing coverage of the defined set of essential health services.
  - Oregon residents enrolled in commercial health insurance plan, self-insured program, health plan funded by Taft-Hartley trust, or state or local government health insurance pool.
  - An Oregon resident who is enrolled in a medical assistance program.
  - A non-resident of Oregon who is an employee of an employer located in Oregon; if the employee's physical worksite is in Oregon.

Section 13 - Evaluation

- OHPR Administrator (with help from OHREC and others) will develop a plan for evaluating the implementation and outcomes of the legislation, with particular focus on Medicaid, SCHIP and FHIAP beneficiaries.
- The OHPR Administrator will also develop recommendations for a model quality institute to:
    - Improve methods for collecting and reporting quality information
    - Expand use of electronic health records
    - Develop capacity of workforce to use electronic health records
    - Improve system transparency and public understanding of quality
    - Support Patient Safety Commission's efforts to improve patient safety
    - Improve system infrastructure, integrated care and health outcomes

Sections 14-23 – OHPR moves to DHS

Section 24 – OHF Board gets $1 GF for the 07-09 biennium

Section 25 – OHFB related money to DHS for the 07-09 biennium

- DHS gets $1,215,350 in state funds to carry out required duties
- DHS gets $671,971 in federal funds to carry out required duties

Section 26 – Money is transferred from DAS to DHS

Section 27 – Sections 1 – 13 are repealed 1/2/10

Section 28 – Amendments in Section 15 become operative on 1/2/10

Section 29 – Act takes effect on its passage

Oregon Health Policy Commission
Road Map for Health Care Reform

Creating a High-Value, Affordable Health Care System

Please direct questions on this report or about the OHPC to Gretchen Morley, OHPC Director, at 503-373-1641

July 2007

Office for Oregon Health Policy & Research

Oregon
Theodore R. Kulongoski, Governor

Oregon Health Policy Commission
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Salem, OR 97310
(503) 378-2422, Ext.
FAX (503) 378-5511

July 2007

The Honorable Theodore R. Kulongoski
900 Court Street NE, Room 160
Salem, Oregon 97301-4047

Dear Governor Kulongoski:

On behalf of the Oregon Health Policy Commission, I respectfully submit the attached final report, *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*. The Commission presents this report in response to your February 2006 letter requesting the Commission develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians.

Throughout 2006, the Commission worked collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years. In early 2007, a draft version of the report was shared with the public and feedback was solicited. The final report, which outlines the Commission vision and provides a framework Oregon can use to move the health care system forward, reflects the Commission's work and input from a wide range of stakeholders. The Commission's recommendations were among the many ideas discussed and included in the development of Senate Bill 329 passed by the 2007 Oregon Legislature.

The Commission recommendations are based on a vision of universal participation in an affordable health care system that offers high-value health care and adequate financial protection. High-value health care is high quality, coordinated and safe, efficient and evidence-based, and continuously improving. The following principles shaped the Commission's recommendations:

- Recognize that health care is a shared social responsibility;
- Recommend reforms that can be realistically implemented over the next five years that both improve current existing structures and define new ways to provide more effective health care;
- Recognize that access, cost, transparency, and quality are intertwined and must all be addressed;
- Achieve access for all Oregonians through rational coverage decisions;
- Maintain a broad, strong safety net;
- Encourage delivery system integration and alignment of payment incentives that prioritize prevention, continuity of care, and care management;
- Maximize available financing; and
- Coordinate with other reform efforts in the state.

To create a high-value health system, the Commission recommends the following reforms:

- Create a Health Insurance Exchange to connect individuals and employers with affordable coverage options and public subsidies in a way that currently does not exist in Oregon;
- Require that every Oregonian purchase affordable health insurance;
- Expand publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Explore sustainable, broad-based financing sources that ensure everyone's participation and equalize the burden between employers that offer employee coverage and those that do not.

To create a sustainable system that delivers value and controls costs, the Commission recommends private and public delivery system reforms, including:

- State-driven public-private collaboration on value-based purchasing, managing for quality, and increased transparency;
- Development of widespread and sharable electronic health records;
- Improvements to health care safety;
- Establishment of a primary care home for every Oregonian; and
- Support for community-based innovations that align resources for more cost-effective, higher quality care.

This report is a resource for the Legislature, state agencies and other stakeholders. The information and reform recommendations provided can be used during the implementation of SB 329 and beyond. As tasked by SB 329, the Commission will participate in reform planning and implementation by developing detailed recommendations for a state health insurance exchange, by participating in Health Fund Board subcommittee work on reform financing, and by providing other information, analysis and support to the Health Fund Board.

Recognizing that real reform requires delivery system change, the Commission plans to include in this work a focus on changing system incentives to improve health care quality, safety, and transparency. The Commission's Quality and Transparency Work Group also stands ready to help the Office for Oregon Health Policy and Research develop a quality institute model as directed by SB 329.

The Commission looks forward to engaging in additional health care reform discussions with you, the State Legislature and other interested parties across the state. Together we can make the changes that will improve Oregonians' access to high quality, effective and efficient care.

Sincerely,

Kerry Barnett
Chair

Oregon Health Policy Commission
Road Map for Health Care Reform

Table of Contents

Oregon Health Policy Commission

The Commission acknowledges the contribution to this report from:
OHPC Local Delivery Systems Workgroup
OHPC Quality and Transparency Workgroup
Safety Net Advisory Council
(See Appendix A for a full listing of workgroup and council members.)
Dr. John McConnell, Oregon Health and Science University, Portland, Oregon whose work was supported by a grant from The Northwest Health Foundation, Portland, Oregon.

Oregon Health Policy Commission
Road Map for Health Care Reform

Executive Summary

The Oregon Health Policy Commission (OHPC) was asked by Governor Kulongoski to develop recommendations for a system of affordable health care that is accessible to all Oregonians. The Commission has worked diligently and collaboratively to develop concrete, realistic reforms that can be implemented over the next five years. The recommendations outlined in this report propose a road map for reform and act as a resource for the Governor, state legislators, state agencies, and other stakeholders during the implementation of Senate Bill 329 and beyond.

Vision

Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives. A high-value health care system is one in which all Oregonians: participate in both the benefits and the costs of a reformed system; have access to affordable, coordinated, high quality health care; and are adequately protected against financial ruin associated with catastrophic medical expenses. A high-value health care system will ensure efficient, evidence-based care and support continuous improvement.

Why Reform Is Needed

The health care system we have now is inefficient, expensive and often fails to ensure good outcomes. Health care costs are high and continue to rise. Increasingly unaffordable health care jeopardizes Oregonians' health status and the state's economic future. In 2006, one in six Oregonians (576,000 people, including over 116,000 children) were uninsured. Low-income Oregonians are at increased risk, but many employed individuals also lack insurance coverage. The uninsured are less likely to get routine care and more likely to delay treatment, resulting in serious and costly conditions. In addition, many Oregonians lack both access to care and to information about costs and quality standards. Without good information, it is difficult for people to be active participants in their own care.

All Oregonians pay for system inefficiencies and services for the uninsured through higher medical bills and insurance premiums, increased consumer prices, and higher taxes. Providers treat uninsured patients, providing care for which they are not paid. To recoup their costs, providers must increase costs to insured patients through higher charges to insurers. Employers pay more for insurance for their employees and are hurt by work time lost to illness. In 2003, the Institute of Medicine estimated that the 41 million people without insurance in the United States cost an annual total of $65 billion to $130 billion.

The economic and human costs of these system inefficiencies must be addressed. To do this, the Commission started with the following guiding principles for health care reform.

OHPC Guiding Principles for Health Care System Reform

- Health care is a shared social responsibility. Everyone must take responsibility for reform.
- Oregon needs a plan that can be realistically implemented over the next five years by improving existing system structures and defining new ways to provide care more effectively.
- The health care system will be sustainable only if reforms address the relationship between access, cost containment, transparency, and quality.
- Resources will always be limited, so coverage decisions must be made through a rational process to achieve access for all Oregonians.
- Reforms must both increase insurance coverage and maintain a strong safety net that serves those who lack insurance.
- Delivery system reforms must improve service integration and align payment incentives to prioritize prevention, continuity of care, and care management.
- We must reduce health disparities based on race, ethnicity, geography, and income.
- Reforms must maximize available federal (especially Medicaid), state, and private financing.
- Coordination with other reform efforts in the state is essential to achieve concrete reforms.

Reform Recommendations

Create a high-value health care system through the following state policies:

- A Health Insurance Exchange, an entity that can bring individuals, affordable coverage options, employers, and public subsidies together in a new and more effective way;
- A requirement that every Oregonian obtain affordable health insurance;
- Publicly-financed coverage and insurance subsidies to ensure affordable coverage for lower-income Oregonians; and
- Sustainable system financing, including a broad-based employer contribution**.**

Create a high-value health care system by implementing both public and private delivery system changes including:

- Drive public-private collaboration on value-based purchasing, managing for quality, and making the system more transparent;
- Develop widespread and sharable electronic health records;
- Improve health care safety;
- Help all Oregonians establish a primary care home; and
- Support community-based innovations that align resources for more cost-effective, higher quality care.

The OHPC reform plan also underscores the need for a thoughtful evaluation plan to monitor the success of reforms.

Oregon Health Policy Commission
Road Map for Health Care Reform

Overview of Recommendations

Vision: Provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.

Recommendation 1: Establish universal health insurance coverage for children.

Lack of insurance affects 116,000 Oregon children; 12.6 percent of the state's children have no insurance. These children represent 20% of Oregon's total uninsured population. Providing affordable health care to all children is a concrete investment in Oregon's future. Proposals currently being discussed in the state would:

- Improve and expand access to Oregon's Medicaid and SCHIP programs;
- Expand health care coverage for children by giving parents with moderate family income (income above the current cut-off for federal program eligibility) the opportunity to buy affordable, state-subsidized group coverage for their children; and
- Continue to expand school-based health centers.

Recommendation 2: Create a Health Insurance Exchange to bring together individuals and employers with affordable coverage options and public subsidies.

The Exchange will operate as a central forum for individuals and small business to buy health insurance. It will be governed by an independent board that will use all of the tools currently available to purchasers, including plan design, to support value-based (quality and cost) purchasing and encourage individuals to manage their medical care and their health. Individuals will use the Exchange as a one stop shop for information and access to insurance options, including access to subsidies for private market coverage.

The Exchange will:

- Define an array of insurance plans available for purchase through this entity;
- Be a "smart buyer" for government and participating individuals and business, driving market change and delivery system reform through plan design, member education and incentives, quality reporting and incentives, cost controls, and other value-based purchasing;
- Define an "affordability standard," an assessment of how much Oregonians can be expected to spend for health care and still afford to pay for housing, food, and other necessities;
- Be utilized on a voluntary basis;

- Attract small employers by minimizing employer administrative burden and providing increased employee plan options;
- Drive quality by negotiating and collaborating with insurers and producers; and
- Act as a market organizer that can respond to and implement future state health care reforms.

Recommendation 3: Require all Oregonians to have health insurance to protect their health and financial security, spread health care costs over the whole community, and reduce the impact of uncompensated care.

All Oregonians will be required to have health insurance. Affordable access to insurance will be ensured through the Health Insurance Exchange, expanded publicly-funded coverage and subsidies, and concerted delivery system reforms. Universal coverage will reduce premiums for the currently insured. Currently, providers recoup the cost of caring for the uninsured by increasing what they charge insurers for their members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers. With everyone in the market, uncompensated care costs will decrease sharply. In addition, employer-based insurance offerings will increase as all Oregonians demand access to affordable insurance.

Recommendation 4: Offer low-income Oregonians publicly-financed subsidies to ensure insurance is affordable.

Publicly-financed insurance assistance will be made available on a sliding scale to Oregonians with income up to 300% of the federal poverty level (FPL). Preliminary analyses indicate that individuals and families can only begin to afford both necessary household expenses and health care between 250% and 300% FPL.[1] To support this effort, the state will request federal Medicaid matching funds to the highest income level possible.[2]

The OHPC recommends assistance in two forms: direct Medicaid coverage (the Oregon Health Plan) and premium subsidies. Medicaid coverage would be an option for all children with family income up to 200% FPL, and adults with income up to 200% FPL who lack access to employer sponsored insurance.[3] Adults with access to employer coverage and everyone with income over

200% FPL will have access to premium subsidies to purchase insurance. Premium subsidies can be used to purchase insurance in the employer or individual markets.

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[1] http://egov.oregon.gov/DAS/OHPPR/HPC/HealthReformResources.shtml

[2] Federal Medicaid funds provide approximately 60 cents on every dollar spent on federally approved insurance coverage. Recently, Massachusetts received approval from the federal Centers for Medicare and Medicaid Services for its Medicaid waiver amendment allowing federal matching funds up for premium subsidy expenditures paid on behalf of individuals with income up to 300% FPL. Until this approval it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

[3] The OHPC recommends maintaining Medicaid coverage currently available for populations that are "categorically" eligible under federal Medicaid law (including children, pregnant women, the elderly, and people with disabilities).

Publicly-financed coverage will be comprehensive and emphasize preventive services and care for chronic conditions. The Prioritized List of Health Services, including proposed changes to increase the List's prevention and chronic care focus, will provide guidance to public coverage decisions.

Recommendation 5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes.

To ensure quality health care for all Oregonians, reform must both improve the delivery system and expand access. Access and delivery issues exist at the local as well as the state level. With this in mind, the OHPC recommends the following:

- Create an independent institute that will develop and promote methods for improving quality information collection, measurement, and reporting;
- Continue efforts to create a stronger, more coordinated statewide effort on value-based purchasing to improve the ability to measure, report, and improve the system.
- Provide leadership and support to further the development of widespread and shared electronic health records;
- Assure a workforce that can capitalize on health information technology;
- Encourage purchasers, providers, and state agencies to improve system transparency and public understanding of quality in health care;
- Support the Oregon Patient Safety Commission's efforts to increase collaboration and state leadership to improve health care safety; and
- Mobilize a coordinated effort among all state purchasers (PEBB, OMIP, Medicaid) and insurers to support new delivery models and new reimbursement strategies that are more effectively supporting infrastructure investments, integrated care, and improved health outcomes.

Recommendation 6: Support community efforts to improve health care access and delivery.

Reform efforts need to be flexible enough to provide local communities the ability to align available resources with the needs and characteristics of their communities. To support local innovation in health care delivery, the Commission recommends the following:

- Promote the primary care model;
- Support local access collaboratives; and
- Create pilot projects to demonstrate ways to realign payment incentives to improve health outcomes.

Recommendation 7: Establish sustainable and equitable financing for reform.

The OHPC proposes simultaneously working toward universal coverage and improved system efficiency. To fund a coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that can be phased out as system efficiencies take hold over the following years.

The financing needed to fund public coverage and premium subsidies is an investment that will make Oregonians healthier and produce savings throughout the state. This investment, implemented along with the delivery system initiatives outlined in this report, will lead to more productive employees, increased efficiency, and reduced system costs.

To implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. Financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Recommendation 8: Design and implement evaluation of system reform.

The OHPC recommends developing a coherent, stable and coordinated evaluation infrastructure prior to reform implementation. To assess success and inform future policy decisions made by the Legislature and state officials, any reform plan should include a well-developed evaluation plan that includes assessment of changes from the pre- to post-reform period and the extent to which reform implementation matches program goals and intentions. The evaluation plan should include metrics for provider capacity, population demand, provider and consumer participation, utilization patterns, changes in health outcomes, health disparities and quality, financial impacts and special issues of concern such as crowd-out, use of technology, and transparency. Sustainable evaluation funding and a central evaluation entity must be identified in order to assure evaluation is coordinated with reform.

Oregon Health Policy Commission Road Map for Health Care Reform

Introduction

Background

Throughout 2006, public interest in solving the growing problems in Oregon's health care system has increased dramatically. There is widespread agreement that our health care system is too expensive, confusing, inefficient and inaccessible, and does not adequately promote health.

Since 2004, the Oregon Health Policy Commission (OHPC) has served as a forum for exploring broad health reform ideas and evaluating promising improvements to the state's health care system. In February 2006, Governor Kulongoski asked the Commission to develop recommendations for establishing a system of affordable health care that is accessible to all Oregonians. Throughout 2006, the Commission worked diligently and collaboratively to develop concrete, realistic reforms that Oregonians can implement over the next five years.

This report outlines the OHPC vision and provides a framework Oregon can use to move the health care system forward. The OHPC report is intended as a resource for the Governor, Legislature, state agencies and other interested stakeholders, providing information and recommendations on reform options and funding mechanisms. The Commission will use this document as it participates in reform discussions during and beyond the legislative session, providing information, participating in analysis and discussions, and encouraging action on comprehensive, meaningful reform at the state level.

Vision for a High-Value, Affordable Health Care System

The Commission presents reforms that would **provide all Oregonians affordable access to a high-value health care system that ensures positive outcomes and promotes healthy lives.** [4]

Affordable access requires:

> **Universal Participation.** A reformed health care system is a shared social responsibility. All Oregonians must participate in both the benefits and costs. Everyone must seek out affordable health insurance whether through a private or public option.

[4] In developing its reform vision, the OHPC drew significantly on the Commission's 2004-2006 discussions and the vision statement of the Commonwealth Fund's Commission on a High Performance Health Care System. Additional sources included the Oregon Public Employees' Benefit Board 2007 Vision, SB 27 (1989 legislation that created the Oregon Health Plan), the Senate Interim Commission on Health Care Access and Affordability (2006), the Archimedes Movement, the Oregon Business Council's Healthcare Initiative and the federal Citizens Health Care Working Group (2006).

Universal participation also means everyone must accept the personal responsibility to seek preventive and disease management services in order to avoid later serious illness that negatively impact health and increase health care costs.

Affordable Health Care for Everyone. Every individual and family not only has affordable health insurance, but also insurance that provides access to affordable health care. Insurance that does not provide adequate access to providers or requires individuals to pay more out of pocket than they can reasonably afford does not provide access to affordable health care. A system with real access provides care in a way that reduces health disparities between population subgroups.

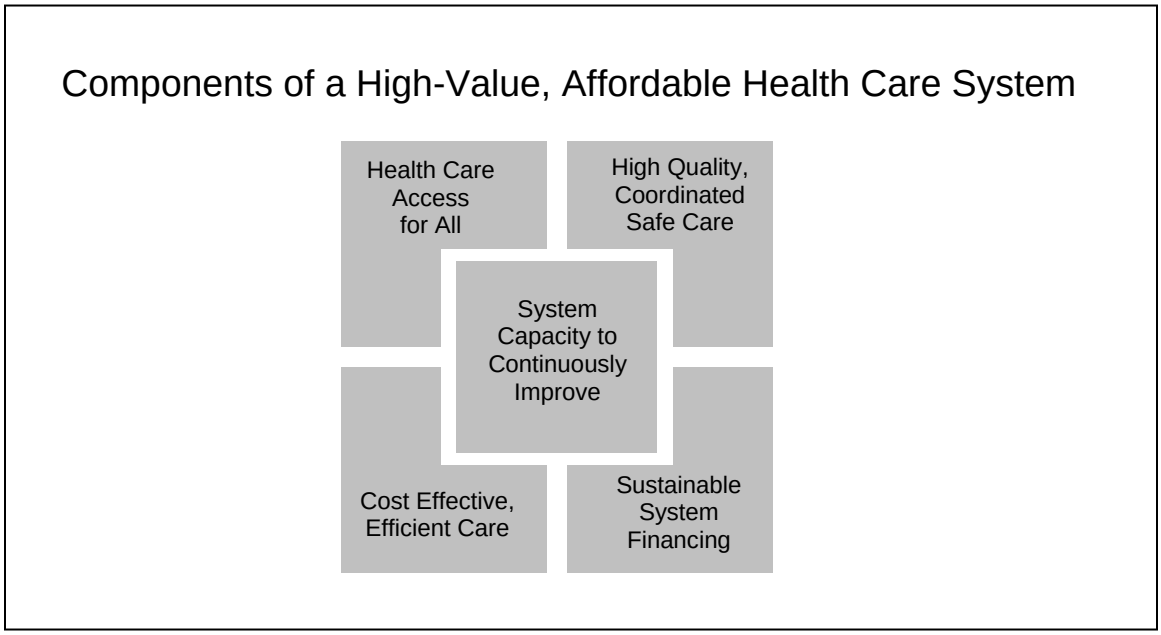
Adequate Financial Protection. A well-operating system will adequately shield individuals and families from the devastating debt that can occur from unexpected accidents and illness.

High-value health care is:

High Quality, Coordinated and Safe. The system should focus on improving quality and health outcomes. Everyone needs a primary care home where care is organized, coordinated, and integrated across providers and over the life of the individual. The care provided must be patient-centered, consciously involving patients as informed and active participants.

Efficient and Evidence-based. Our health care system must be an integrated system that gives consumers and providers the market incentives to provide the right care at the right time and in the right setting. Access to health care does not mean access to all available services. New technologies, procedures, and treatments must be evaluated for effectiveness and value. The health care system needs to use evidence-based medicine to maximize health and utilize dollars wisely.

Continuously Improving. Our health care system needs the tools to capitalize on innovation and integrate research findings into practice. We need system-wide transparency through available and understandable information about costs, outcomes, patient motivation, and other useful data. We need an information technology infrastructure that supports integration, transparency, and quality and is available when and where both patients and providers need information for decision-making. We must have a statewide strategy to address the critical needs for the health care workforce of the future.



Symptoms of the Broken System We Have Now

Cost Increases Harm Oregon

Health care expenditures in the United States were almost $1.9 trillion in 2004, over two and a half times the 1990 spending and 16.0% of the Gross Domestic Product. Since 1998, health insurance premiums have risen substantially, outpacing inflation and impacting individuals, employers, and government. Rising costs jeopardize Oregonians' health status, make the state and nation less competitive, and make adequate investment in other crucial areas such as education more difficult.

System Impacted by Poor Quality of Care

The Institute of Medicine has documented the existence of a "quality chasm" in the United States.[5] Recent research indicates that Americans receive recommended care only about 55 percent of the time.[6] The IOM estimates that between 44,000 and 98,000 Americans die each year from preventable medical errors in hospitals. Almost one third of health care expenditures pay for care that is duplicative, fails to improve patient health, or may even make it worse.[7] A recent Commonwealth Fund study found the United States health care system less efficient than other countries, as measured by duplicated tests, repeated medical histories, and medical records not available at the time of the visit.[8]

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[5] A list of IOM reports on quality issues is available at http://www.iom.edu/CMS/8089.aspx.
[6] "Who Is at Greatest Risk for Receiving Poor-Quality Health Care?" Asch SM, et al., *New England Journal of Medicine*, Vol. 354, No. 11, March 16, 2006, pp. 1147-1156.
[7] "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Elliott S. Fisher, et al., Annals of Internal Medicine, February 2003; 138: 273 - 287.
[8] "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," Schoen, Cathy et al. *Health Affairs.* Nov 28, 2005.

Too Many Oregonians Lack Insurance
In 2006, 15.6% of Oregonians were uninsured.[9] Over 576,000 Oregonians, or one in six residents, were uninsured; 116,000 of those were children. Another 258,000 Oregonians experienced a gap in their health care coverage at some time during the year.

While 15.6% of Oregonians aged 19 to 64 are uninsured, 44% of poor adults lack coverage. In 2004, 21% of children in families with income under 100% of the Federal Poverty Level were uninsured, compared to 19% of all children in Oregon. Even when a parent has access to coverage, their children may be uninsured because family coverage is not offered or affordable. Many families do not know their children are eligible for Oregon Health Plan coverage; still others find it too difficult to enroll or prefer not to access a public program.

Employment Not a Guarantee of Coverage for Low and Moderate Income Oregonians
Contrary to what many believe, a high percentage of employed persons do not have insurance. Even those working for employers that offer insurance may not be able to afford the insurance offered. Seventeen percent of individuals in families with at least one full time worker lack health insurance, and 33% of those with part-time employment lack health insurance. 56% of uninsured Americans are not eligible for Medicaid or other public sector health programs and cannot afford to buy coverage on their own.[10]

Lack of Coverage Hurts Access to Cost-Effective Prevention, Health Maintenance
Although insurance coverage does not guarantee access to services, the uninsured are less likely to access cost-saving preventative services or to seek treatment for illness or injury until the problem is not manageable and the hospital emergency room seems the only option.

The uninsured are less likely to seek regular care, and they are four times less likely to have a regular source of care than are the insured.[11] Uninsured children are nearly three times less likely to have seen a physician in the past year than are children with insurance coverage.[12] Almost 40% of people who delay care cite lack of insurance and cost as the main reasons they did not see a provider.[13] Without treatment, chronic problems can become acute and require costly and avoidable emergency treatment.[14] Lack of insurance both shortens productive years of work and undermines the standard of living for families and individuals faced with large medical

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[9] *Profile of Oregon's Uninsured, 2006*, Office for Oregon Health Policy and Research. February 2007. Report is based on the 2006 Oregon Population Survey, a biennial statewide telephone survey of Oregon households. CPS data released in August 2006 indicates the national uninsurance rate was 15.9% in 2005.
[10] "The Uninsured and the Affordability of Health Insurance Coverage," Lisa Dubay, John Holahan, Allison Cook. *Health Affairs* 26, no. 1 (2007).
[11] "Demographic Characteristics of Persons Without a Regular Source of Medical Care – Selected States, 1995," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, 1998, 47: 277-79. For general statistics, see http://www.eoionline.org/HealthCareUninsuredDilemmaFS.pdf.
[12] *Health Insurance? Its Enough to Make You Sick*. Philadelphia: American College of Physicians-American Society of Internal Medicine, November 1999.
[13] "Entry Into Prenatal Care --- United States, 1989-1997," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, May 12, 2000, 49 (18): 393-8. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4918a1.htm.
[14] "Unmet Health Needs of Uninsured Adults in the United States," John Ayanian, et al., *Journal of the American Medical Association,* October 25, 2000, 284:2061.

expenditures. Nationally, the 41 million uninsured cause an estimated annual loss of $65 billion to $130 billion due to poorer health and earlier death.[15]

All Oregonians Impacted by the State's High Uninsurance Rate
The uninsured delay needed care, but can not avoid it entirely. When people without insurance get care in high cost settings such as emergency departments or hospitals, they can often not afford to pay for the services they have received. Providers that have cared for these individuals must make up for their expenses. For the most part, providers rely on the insured to help pay for services for the uninsured. Providers recoup the cost of caring for the uninsured by charging insurance carriers more for services rendered to carriers' members. Higher charges to insurance companies are then translated into increased premium costs to individuals and employers.

Lack of Information Is Endemic
In our current system, it is difficult for patients to get clear and comparable information about health care costs and standards of care. Individuals pay different amounts for the same procedures based on their insurance status. The lack of information makes it hard for patients and their families to be active participants in their own care. Without full information, patients can not make the best clinical and economic decisions.

Fragmented Service Delivery Does Not Support Quality
Most behavioral health providers and treatments operate separately from physical health care. The historic lack of parity in insurance coverage for behavioral health care exacerbates the difficulties many people have accessing mental health care and substance abuse treatment. While a mental health parity law took effect in Oregon on January 1, 2007, more must be done to ensure that those in need can have behavioral health issues effectively and responsively identified and treated. Another area of care that remains disconnected from acute care services is long term care. Although integration would improve patients' health, acute care providers are generally not given incentives or other support to coordinate with long term care providers.

A fragmented delivery system also makes it very difficult to design a reimbursement system with incentives that align for payers and providers. In the current system, it is too easy to push financial responsibility to other parts of the system, making the system less accountable for results. It is relatively easy for each piece of the system to maximize its reimbursement when no one takes responsibility for the big picture or the interrelationships.

[15] "Covering the Uninsured: What is it Worth?", Wilhelmine Miller, et al. *Health Affairs – The Uninsured, Value of Coverage* Web exclusive. March 31, 2004. The Institute of Medicine, in its June 2003 report *Hidden Costs, Value Lost: Uninsurance in America*, estimated the value of improved health for a currently uninsured individual who gains coverage at between $1,645 and $3,280 a year.

OHPC Guiding Principles for System Reform

Recognize that assuring health care is a shared social responsibility. This includes both a public responsibility for the health and security of all Oregonians, and the responsibility of everyone to contribute. Individuals, employers, government, and providers are mutually responsible for creating, financing, and sustaining an affordable health care system.

Develop reform recommendations that can be implemented over the next five years. The OHPC recommendations primarily focus on what Oregon can do right now to achieve significant reform. The OHPC recognizes there are efforts underway to reform state and federal health policy to achieve broader reform. By outlining steps the state can take today, the OHPC recommendations are not inconsistent with these other reform efforts.

Support and improve current programs and structures that work, overhaul the ones that do not. To promote short-term reforms that help achieve the longer term vision of a high-value, affordable health care system, the reform plan needs to both utilize existing programs and define new ways for the uninsured to access care. Unnecessary complexity leads to confusion, cost, and errors. Both the delivery system and the administration of new and existing programs must be streamlined in order to be accessible and comprehensible. Changes must improve access and care for Oregon's vulnerable populations, including racial and ethnic minorities, individuals in geographically underserved areas, and low-income Oregonians.

Recognize that access, cost, transparency, and quality are intertwined. To develop a high-quality system, we must address problems such as an inefficient delivery system, medical errors, and uncontrolled cost growth. Access, cost containment and quality must all be valued in order to achieve a sustainable system. Quality care relies on patients, providers, and employers having transparent access to appropriate health care information.

Achieve access for all Oregonians through rational coverage decisions. To stay within budget constraints, it is better to promote access to primary and chronic care services rather than limiting services to emergency access. Services can be limited and directed in order to maximize the number of people who get both health insurance and real access to needed services. The Prioritized List of Health Services has been used successfully in Oregon's Medicaid program since 1989. The Commission believes the expansion of basic health care to all Oregonians should utilize the Prioritized List and prioritize health promotion, disease prevention and disease management.

Emphasize care that prevents and manages disease, engages patients in their own care, and protects families from catastrophic health care costs. Ten percent of our population is responsible for 69% of health care costs. In order to produce the greatest return on investment and control health care costs, health reform must emphasize health care services that seek to prevent and manage disease and must find more effective ways to engage patients in their own care. Additionally, as with car insurance, health insurance must provide protection against catastrophic losses. A recent Commonwealth Fund study found that 21 percent of adults surveyed (both insured and uninsured) said they are struggling to pay off medical debt.

Maintain a broad, strong safety net. Over the past few years, Oregon's safety net infrastructure has been stretched thin. We recognize that there will always be times of transition during which individuals are not eligible for available coverage. A meaningful coverage system requires a strong safety net to provide quality care and access to both patients without access to insurance coverage and those with insurance.

Encourage delivery system integration and alignment of payment incentives. Consumers and providers must have incentives and information to make health care decisions that drive quality and control cost. The state should take a clear leadership role through its public insurance programs. Additionally, state policy should recognize and support the many community efforts underway across Oregon to align resources and form partnerships to improve local health care delivery systems.

Maximize available financing. Coverage for all Oregonians can only be achieved by doing all that is possible to optimize available sources of revenue. As everyone in Oregon is sharing in the cost of the current inefficient system, we must identify, capture, and reinvest savings produced from successful reforms. Maximizing available federal Medicaid financing is paramount.

Coordinate with other reform efforts in the state. Many groups are working to develop policy reforms and garner support to move reforms forward. The OHPC will draw ideas from and seek connections between these efforts to the extent possible in order to help channel this energy into true change.

Public Health and Disease Prevention: Health Is More than Health Care

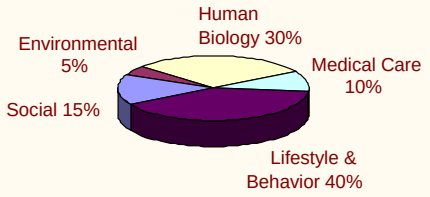
When it comes to our health, we leave the barn door open until the horses get out. In spite of the billions of dollars funneled into the U.S. health care system, we fail to capitalize on the profound and far-reaching impact that disease prevention and wellness programs can have in improving our quality of life and reducing the social and economic burden of avoidable acute and chronic diseases. We know that health is determined by far more than medical care.[1] Both Oregon and the nation are falling short of achieving the best health for our citizens when we focus most of our resources on acute care after our health is lost.

Invest in Health

Historically, public health interventions have had a greater effect on health outcomes that any medical interventions. Life expectancy has quadrupled in the last 150 years due to basic (though often controversial) measures such as municipal water treatment, hand washing, food safety measures, vaccination programs, and fortification of food staples such as bread and milk with essential vitamins and minerals. Yet for the first time in American history, a child born today has a shorter life expectancy than her parents.[5] Modern technology has created new obstacles to health in our society and we are again faced with changing our public environment to maintain and improve the public's health.

One third of deaths in Oregon can be attributed to just three unhealthy behaviors: tobacco use, lack of physical activity and poor eating habits. These behaviors often result in and exacerbate chronic disease. Heart disease, cancer, stroke, respiratory disease and diabetes account for two of every three deaths in Oregon.[2] Furthermore, one out of every three years of potential life lost before the age of 65 is due to a chronic disease.[3] These chronic diseases reduce the quality of life of individuals, burden families and friends, and are responsible for massive health care expenditures.

Factors Influencing our Health [4]



Invest in Knowledge

There is also a need for more public health research, particularly in the area of health disparities between racial and ethnic groups. Such disparities are reflected in stark differences in life expectancy; rates of disease; disability and death; disease severity; and access to treatment.

[1] Oregon Vital Statistics Annual Report 2004, Vol. II, Chapter 6. Mortality.
[2] *Ibid*
[3] *Ibid*
[4] McGinnis J.M., Williams-Russo, P., Knickman, J.R. (2002). *Health Affairs,* 21(2), 83.
[5] "A Potential Decline in Life Expectancy in the United States in the 21st Century," S. Jay Olshansky, et al., *The New England Journal of Medicine*, March 17, 2005, Volume 352:1138-1145, Number 11.

What can be done?

Public/private partnerships - our public health interventions and health care systems can work together on disease prevention and effective care management, giving us a fighting chance to overcome the unhealthy behaviors and racial health disparities that we face today.

Make the healthy choice the easy choice - foster environments that encourage healthy lifestyle choices in our daily lives. That means making health a priority in schools, the workplace, community development, and in our homes.

Some of this work is already underway

This fall, Northwest Health Foundation and Community Health Partnership: Oregon's Public Health Institute were successful in bringing public and private health entities together around a common agenda for the 2007 legislative session.[1] Some needed policy changes supported by these groups, as well as the OHPC, include:

- More data collection that is targeted to relevant policy and spending decisions
- Community water fluoridation
- Statewide school nutrition standards

The Commission's report, *Promoting Physical Activity and Healthy Eating among Oregon's Children* provides public officials and the public at large with a detailed resource for attacking the trend of obesity and resulting illnesses in Oregon's children.[2] This report was assembled by a team of local and national experts from a variety of fields, including medicine, public health, education, and land-use planning.

Additionally, an exciting new partnership between the Northwest Health Foundation, the Oregon Public Health Division and the OHPC will make public health data accessible to policymakers and generate the community engagement vital for effective public health programs.

1 For more information, see http://www.communityhealthpartnership.org/images/pages/newsletters/dec_06.pdf.
2 *Promoting Physical Activity and Healthy Eating among Oregon's Children: Draft Recommendations to the Oregon Health Policy Commission*, DHS Office of Family Health. October 2006.
3 Community-Created Health Care Solutions in Oregon, Oregon Health Policy Commission, January 2006.

Solutions for the world we live in

We know intractable social issues like poverty and poor education have significant negative health impacts, yet there is much that can be done within the health care system to mitigate the impact of those larger problems. To begin:

1. Put high priority on prevention services, such as immunizations and health education, to avoid illness and injury in the first place. Public and private purchasers and insurers need to align payment incentives to encourage preventive care and chronic disease management.

2. Integrate public health and health care systems. Currently the public health system and the health care system operate separately and often in competition. Collaborative community efforts are underway in 19 counties across the state to coordinate local resources and improve the health of their communities[3]. These community partnership efforts are well positioned to help public health and health care systems begin to work in concert.

Oregon Health Policy Commission Road Map for Health Care Reform

Recommendations: Building a High-Value, Affordable Health Care System in Oregon

This section outlines the concrete reforms Oregon can implement to move the state toward realizing a high-value, affordable health care system over the next five years. Reform will only be sustainable if it is both short- and long-term focused. In the short term, Oregon needs to expand health care access to the growing number of uninsured. However, Oregon also needs to recognize that uninsurance is a symptom of a much deeper problem with how health care is delivered and financed. Over the long-term, we need to address these deeper systemic problems or our efforts to expand access will not be sustainable.

No one actor can make it happen. Reform is an effort that requires all of us – consumers, health care providers, insurance carriers, policymakers – to look beyond our immediate separate interests, to a future with a more equitable, higher quality, and efficient health care system for all. Reform cannot happen overnight. While there is no magic bullet, there are "pressure points" in the system that can be leveraged to achieve reform. The Oregon Health Policy Commission (OHPC) recommendations spotlight those pressure points, outlining how they can be enhanced and be more effective. These recommendations are a reference for health care reform discussions in the implementation of Senate Bill 329 and beyond.

Note on the OHPC Approach

Of the guiding principles upon which the OHPC recommendations were built, two form the backbone of the recommendations.

First, the Commission recognized that reforming the health care system is a shared responsibility. In order to ensure affordable access to health care for everyone, everyone must contribute. The OHPC recommendations operationalize this principle through an individual coverage requirement, publicly-financed subsidies, and a broad-based financing source that includes employers. The OHPC also recommends establishing a Health Insurance Exchange, an entity that can bring these pieces together in a new way to serve individuals and small business.

Second, the Commission sought to develop reforms that can be implemented in the near term in order to work toward reform now and over the next few years. This report recommends changes that do not require large-scale federal changes occur before reform can be implemented in Oregon. The Commission believes that changes to federal policy and funding mechanisms are needed but are not necessary for implementing the recommendations in this report. All of the

reforms outlined in this report can be implemented over the next several years, and can be modified later to take advantage of federal policy changes.

Federal Policy Changes to Support Health Reform in Oregon

The Oregon Health Policy Commission's reform proposals seek to create a road map to affordable health care access, outlining reforms the state can implement within current federal constraints. The state should not wait until major policy changes are made at the federal level to push forward with reform. However, there are many federal policy changes that would give Oregon needed flexibility and institute greater equity and stability in the health care system. Some of OHPC's top federal priorities are outlined below.

Force a national dialogue on health care reform and federal health care financing: The OHPC supports comprehensive health reform at the federal level that rationalizes how federal funds are spent on health care.

Increase Medicare provider payment rates: Medicare provider payment rates in Oregon are among the lowest in the country, increasing the cost-shift to those insured through the private sector.

Adjust the Medicaid matching formula to avoid penalizing states during an economic recession: The current Medicaid federal medical assistance percentage (FMAP) formula does not adjust quickly enough to changes in states' economic conditions. The FMAP should be modified to account for periods of economic downturn to ensure that states are getting more federal funding when the demand for their programs is greatest.

Provide states with flexibility under ERISA: The Employer Retirement Income Security Act (ERISA) of 1974 preempts states' ability to regulate employer benefit offerings, including health insurance. This blanket preemption limits states' ability to develop reforms that establish minimum requirements for employer-sponsored insurance. In absence of federal reform, the OHPC supports instituting a waiver process that allows states to apply for waivers of ERISA in order to enact state-level reforms.

Change federal tax policy to support individual insurance purchase: While people who purchase health insurance through an employer can pay premiums with pre-tax dollars, individuals buying insurance in the individual market get no such benefit. To encourage insurance purchase by the self-employed and others without access to employer-sponsored insurance, the federal government should allow individual insurance purchase to be federally tax deductible.

Recommendation #1: Establish Universal Health Insurance for Children

Proposal Overview

Governor Kulongoski's 2007-2009 Recommended Budget included implementation of the Healthy Kids Plan.[16] The Oregon Health Policy Commission (OHPC) supports the funding and implementation of Healthy Kids, which will provide comprehensive health care (including medical, dental, vision, and mental health) to all of Oregon's uninsured children up to age 19. Building on existing programs, it will allow low-income families to enroll their children in public coverage or to use subsidies to purchase private coverage for their children. In addition, the program provides an opportunity for families not eligible for public programs or subsidies to buy affordable coverage through a separate program. The OHPC supports the Healthy Kids efforts to improve and expand access to comprehensive health insurance and continue expanding school-based health centers to increase access to care.

Programs for Children Based on Income, Access to Private Coverage
For children in families with income up to 200% of the federal poverty level (FPL), benefits will continue to be provided through the Oregon Health Plan, with dental, vision, and mental health care, no co-payments and no family premium share. Low-income families may also access the Family Health Insurance Assistance Program, which provides premium assistance allowing a family to purchase insurance through a parent's employer.

Children in families with income at 200% FPL and above with no access to employer-sponsored insurance will have access to comprehensive coverage through a private insurance product. Families will have assistance in choosing a plan and premium subsidies will be based on income. Health plans may compete to participate. Children in families with income above 350% FPL may still enroll in Healthy Kids but must pay the full cost of the coverage.

Cost to Families
The Healthy Kids program was designed based on conversations with Oregon families about what is affordable. Premium assistance will be income-based. Higher income families will pay affordable monthly premiums and co-payments.

[16] The Governor's Healthy Kids Plan draws on recommendations from the Medicaid Advisory Committee and a series of public hearings. For more information, see: http://egov.oregon.gov/DAS/OHPPR/MAC/docs/HealthyKidsReport.pdf

Why Change Is Needed

In 2006, an estimated 116,000 Oregon children were without health insurance. About half of them qualify for state programs but are not enrolled. Many children in Oregon lack access to providers and basic health care services. Uninsured children face additional barriers to care. They are half as likely to get preventive care or see a doctor as those who are insured.[17] Children without insurance are more likely to use expensive emergency room for care and to be hospitalized. Poor health makes it harder for children to learn. Illness and chronic conditions lead to missed days of school and poorer performance. Keeping kids healthy also saves money.

More than half the uninsured children in Oregon have employed parents. Many families earning between $40,000 and $80,000 a year make too much for their kids to qualify for state programs but struggle to afford health insurance. Families lack coverage for their children for many reasons. Employer-sponsored coverage may not be available to the family or premiums for dependent coverage may be too expensive. In addition, enrollment barriers keep some families from enrolling their eligible children in public coverage. The OHP application process can pose difficulties to working families The requirement that eligibility be recertified every six months means that families must re-do paperwork twice a year. Some families are unaware that their children are eligible for OHP even when their parents are not.

Selected Implementation Considerations

To make Healthy Kids work, the state will partner with community organizations to reach out to uninsured children and help families enroll their children (and keep them enrolled). To facilitate enrollment and maintain eligibility, the state will utilize a shorter application, 12-month enrollment period, a reduced (two month) uninsurance requirement, and no asset test. To assist children where they are, school-based health centers (SBHC) will be expanded and supported. At least five new SBHCs will be funded in counties without existing health centers. At least five additional SBHCs will be funded in counties that already operate one or more SBHC.

Other Healthy Kids programs include the expansion of the dental sealant program that will seal the teeth of 50% of all 8-year-olds by 2010. This compares to 30% of uninsured children who currently have dental sealants. Additionally, a nurse advice line will provide families with access to information that will allow children to get the best care in the most appropriate setting.

[17] *Children's Access Survey*, Jen DeVoe, Lisa Krois, Tina Edlund, Jeanene Smith. January 2006.

Recommendation #2: Establish a Health Insurance Exchange to Bring Together Individuals, Coverage Options, Employers, and Public Subsidies

Proposal Overview

The Oregon Health Insurance Exchange is a market organizer that helps purchasers to buy value. It acts as a central forum for individuals and businesses to purchase affordable health insurance.[18] The Exchange is also the mechanism through which individuals can access subsidies for private market coverage.

The Exchange will define an "affordability standard," which is a calculation of how much individuals and families can be expected to spend for health insurance and still afford to pay for housing, food, and other necessities. This affordability standard will be used to define both the insurance packages available through the Exchange and the public subsidies for coverage.

While the Exchange will exist in addition to existing purchasing venues, it should particularly appeal to small employers as an easy, reliable, cost effective insurance source for them and their employees.

The Exchange will be a vehicle for driving quality by negotiating or collaborating with the community of insurers and providers. It will work with insurers to develop packages that manage care, quality and cost. Quality will be built in, through contractually established expectations on insurance carriers, such as pay for performance requirements, including quality measures, prevention focus, self-management, and employee education.

As the Exchange grows, it can create a critical mass of customers who can influence providers and insurers. To ensure enrollment stability, the Exchange will require those insured through the Exchange stay in for a mandatory period.

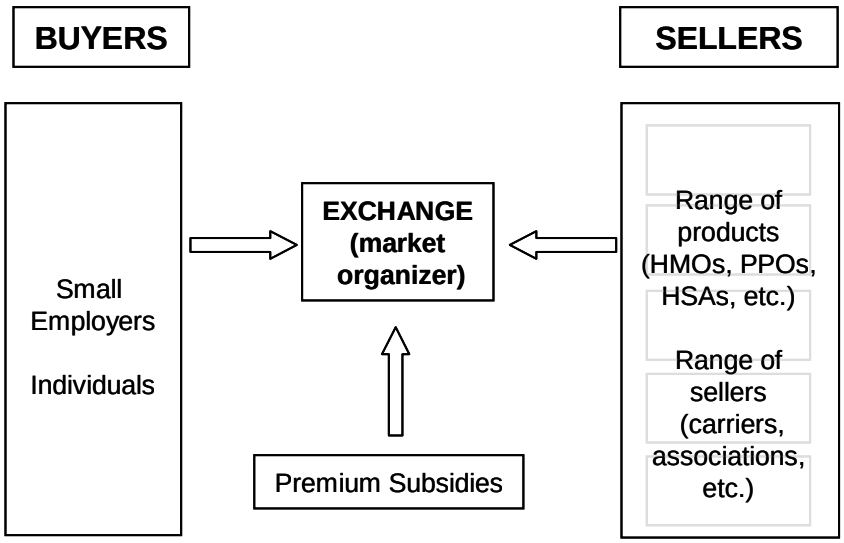
The OHPC recommends establishing the Exchange as an independent organization. It should be shielded from politics and be responsive to stakeholders. The Exchange requires legal, actuarial, and negotiation expertise and must be explicitly given the power to conduct activities such as contracting for services.

Funding for the Exchange should be sustainable and internally generated. Funding mechanisms could include a transaction fee on policies sold through the Exchange, a premium on policies, and a membership fee for insurance providers. Additional funding mechanisms include

[18] The Health Insurance Exchange is similar to the Commonwealth Connector established by Massachusetts, and to the Trust Fund proposed by the Senate Interim Commission on Health Care Access and Affordability.

Medicaid administrative funds. To cover the initial costs, the state should provide the Exchange with start up funds to be repaid once the entity is on solid financial footing.

OVERVIEW OF THE HEALTH INSURANCE EXCHANGE



What Can An Exchange Do For Oregon?

- Act as a single, statewide, centralized exchange for buying and selling insurance in non-large group market
- Aggregate people to influence quality and efficiency of non-large group market
- Facilitate transactions among individuals, insurers, employers, and government
- Provide people with familiar feel of employer-group coverage, with added benefits of individual portability, choice and control

Why Change Is Needed

Employers

Researching insurance options is complex and time consuming, and often falls outside of an employer's expertise. Many small employers, even those who work with brokers, spend considerable effort and time researching available plans and weighing the financial impact of a given insurance product.

Small businesses that provide health insurance for their employees consistently get less for their money, suffering faster premium increases and steeper jumps in deductibles over time than large firms.[19] Small employers can often offer only one plan, which makes it harder to find a plan that fits the needs of all employees.

While small employers face special difficulties in researching and procuring health insurance for their employees, all employers regardless of size face challenges in choosing health coverage that is affordable for employer and employees. The Health insurance Exchange would provide a resource to help employers find quality, affordable coverage.

Individuals
Individuals who lack employer-sponsored health insurance (ESI) and who do not qualify for Medicaid must find their own health insurance. This can be a daunting task for an individual who must weigh costs, coverage limitations and lifetime caps. Information is often not comparable across products and insurers, and legal and medical language is confusing to the lay person.

How an Exchange Adds Value

The Exchange Benefits Employers
The Health Insurance Exchange will offer a variety of insurance product options, from traditional indemnity plans to managed care options and high-deductible health plans with affiliated Health Savings Accounts. This will allow employers to offer employees a range of insurance options - low cost, high coverage and in between. While this is of special interest to small employers that have traditionally been limited to offering a single plan that may not fit all employees' needs, all employers benefit from this function. The Exchange will develop an on-line decision support tool to assist employees, employers, and brokers to compare the benefits and cost of a variety of plans.

The Exchange will be a sustainable source over time for employers offering coverage to their employees. It will be available to employers on a voluntary basis; employers may continue to seek insurance as they currently do. However, the Exchange will be a favorable option for employers because it offers them increased choice and reduced administrative burden.

When working through the Exchange, the employer can allow employees to choose a plan that fits their finances and health needs. The Exchange acts as the pooling mechanism on the employer's behalf, giving employees increased options without increasing employer costs. By providing the employer services such as facilitated plan selection and streamlined access to employee premium subsidies, the employer will experience reduced administrative burden while still providing insurance to their employees.

[19] *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees*, Jon R. Gabel, M.A., and Jeremy D. Pickreign, M.S., The Commonwealth Fund, April 2004. Authors' analysis of Kaiser/HRET 2003 survey of employer sponsored health benefits.

Individuals with greater health needs are more likely to choose plans that are more comprehensive and expensive. Healthier people often value cost savings over more benefits. The Exchange will institute provisions to ensure that the existence of range of plans does not lead to adverse selection by workers with more care needs.

The Exchange Benefits Individuals
The Exchange provides individuals with affordable options. In addition to serving as the access point for eligible individuals' use of subsidies, the Exchange will offer a range of insurance packages, allowing individuals to choose plans that fit their health and financial needs. For example, plans featuring low premiums and streamlined benefits may appeal to young people who currently do not enter the market because they do not think they need insurance.

The Exchange will also allow employed individuals who purchase insurance on their own to use pre-tax dollars to pay health insurance premiums. While pre-tax funds can currently only be used for purchasing insurance when an individual gets insurance through an employer, a statutory change at the state level would allow the self-employed and others purchasing insurance outside of employer-sponsored plans to take advantage of this tax benefit.

For individuals, the Exchange increases insurance portability; the insurance is not tied to an employer or lost when employment changes. An individual whose employer utilizes the Exchange can choose to retain that same insurance through the Exchange even when the individual leaves that employer. This can help people avoid pre-existing condition limitations often associated with changing insurance providers.

The Exchange will offer people a source for coverage they can count on if they need it. Use of the Exchange will be optional with one exception. Individuals and families accessing publicly funded premium subsidies in the individual market will be required to purchase insurance through the Exchange.

Selected Implementation Considerations

Risk Adjustment Options for Consideration
Some insurance carriers may be concerned about unknown risk of a new consumer base. While the Exchange offers the chance for significant new business through the enrollment of previously uninsured populations given the individual mandate, insurers may worry that something unforeseen could cause one carrier to enroll a disproportionately higher number of sicker members. To address this risk selection concern, the state could engage in risk adjustment. Two possible risk adjustment strategies are retrospective smoothing of costs among carriers, and excess-loss claims subsidies to carriers.

Retrospective risk adjustment would involve the state looking back at the costs borne by insurers during a given period, and reimbursing a percentage of costs to carriers with above-average claims costs. With claims subsidies, the state helps pay claims costs for plan enrollees with costs above a set annual limit. Within the risk corridor, the state would pay a percentage of claims.

Realizing the Exchange's Potential Added Value: Areas for Further Research
One potential benefit of utilizing an Exchange for the purchase of health insurance is the expansion of tax benefits to employed individuals not insured through an employer. Currently, individuals purchasing insurance through an employer-sponsored plan can use pre-tax dollars to pay premiums. This effectively lowers the purchase price of the insurance for these individuals.

The Exchange faces additional tax issues upon implementation. Massachusetts (which recently implemented a "Connector" entity that acts like Oregon's proposed Exchange) is currently addressing tax issues related to the implementation of its program. The OHPC recognizes that additional work is needed to identify and respond to tax considerations raised by the goals of a fully functioning Exchange.

One added benefit for employed people that needs additional development is allowing an employee with multiple employers to have more than one employer contribute to the individual's premium. This is not currently available to individuals with more than one job, but could allow people with multiple employers to get help with insurance premiums from employers that may be unable or unwilling to individually contribute the full cost of coverage.

Recommendation #3: Require All Oregonians to Have Health Insurance

Proposal Overview

A central element of the Oregon Health Policy Commission's (OHPC) reform plan is universal health insurance coverage. The OHPC recommends requiring that all Oregonians obtain insurance. To ensure affordability for lower income Oregonians, this individual mandate must be coupled with sliding scale subsidies to help make health insurance premiums affordable (Recommendation #4). Low-income individuals without access to employer-sponsored insurance will be eligible for the Oregon Health Plan. A Health Insurance Exchange (Recommendation #2) will be established to provide a one-stop-shop to facilitate enrollment in a selection of plans and access to publicly-funded subsidies.

Why Change Is Needed

Everyone needs to be insured to protect their health and financial security, spread health care costs over the whole community, and reduce the amount of uncompensated care.

The uninsured who find themselves in a medical crisis have few alternatives to the emergency room. While emergency room care is needed in some situations, it is costly and can often be avoided by making prevention, primary care and chronic care services available and affordable. Making such services financially accessible reduces reliance on high intensity, high cost emergency care, and increases individuals' ability to obtain care in the most appropriate settings.

Bringing everyone into the market will do more than benefit the currently uninsured. It will also reduce the burden of uncompensated care in the system. Hospitals receive state and federal funds to offset some "uncompensated" care; they also pass much of these costs on to insurers. These added costs drive up claims costs which are then reflected in higher insurance premiums. This cost-shift for uncompensated care represents 10% percent of premium costs for insured persons.[20]

Some employees who are offered insurance do not enroll, either because they do not think they need it or because the cost is prohibitive. An individual mandate will require everyone to obtain insurance. This will encourage employees with access to employer-sponsored insurance to use it, capitalizing on the existing employer market.

[20] Calculations by John McConnell, PhD, Oregon Health and Sciences University.

Selected Implementation Considerations

Affordability

The question of what is affordable has four components:

- What can people afford to spend on health care?
- What are the overall program costs (what can society afford to spend)?
- What subsidies are needed to make health care affordable for Oregonians?
- What benefit package can be afforded and sustained given the answers to the three questions above?

In order to calculate what families at different income levels can afford to spend on health care, the OHPC used the Economic Policy Institute's Family Budget Calculator to estimate necessary household expenses on housing, food, childcare, transportation, taxes and other necessities in Oregon.[21] The OHPC removed the health care costs and added 10% for savings. The goal was to estimate the cost of making essential health care affordable for lower income individuals and families in Oregon.

Based on this work, the OHPC proposes affordability levels that policymakers can use to guide reform discussions. The affordability levels presented below represent a maximum portion of family income to be spent on health care costs for a family of three up to 300% of the Federal Poverty Level.[22]

Family income (% of federal poverty level)	Family income (dollars per month)[23]	Maximum percent of income for health care	Maximum family spending on health care (per month)
0 - 149% FPL	$0 - $2,075	0%	$0
150 - 199% FPL	$2,075 - $2,766	5%	$104 - $138
200 - 249% FPL	$2,766 - $3,458	10%	$277 - $346
250 - 299% FPL	$3,458 - $4,149	15%	$519 - $622

Definition of Coverage

To mandate coverage, the state needs a general definition of a basic package of services. The OHPC recommends using Oregon's current broad definitions of insurance that will permit a wide range of insurance plans.

[21] The Economic Policy Institute's Family Budget Calculator is located at: http://www.epi.org/content.cfm/datazone_fambud_budget.

[22] For more information on the affordability analysis used by the OHPC, please see our companion report, available on the OHPR web site at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.

[23] All dollar figures are shown for a family of three. Source: Federal Register, Vol. 71, No 15, January 24, 2006, pp.3848-3849.

For example, the definition of insurance used by Oregon's Family Health Insurance Assistance Program (FHIAP) is as follows:

> A "Health benefit plan" as a policy or certificate of group or individual health insurance that provides payment or reimbursement for hospital, medical and surgical expenses. Such a health benefit plan includes a health care service contractor or health maintenance organization subscriber contract, the Oregon Medical Insurance Pool and any plan provided by a less than fully insured multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act.
>
> A health benefit plan does have limitations, and does not include accident-only coverage, insurance limited to care for a specific disease or condition, limited parts of the body (vision only or dental only coverage), or for services within a particular setting (hospital-only, for example). Other excluded coverage types are credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance, student accident and health insurance, long term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which the benefits are payable with or without regard to fault and that is legally required to be contained in any liability insurance policy or equivalent self-insurance or coverage obtained or provided in another state but not available in Oregon.[24]

Enforcement
Oregonians with access to affordable coverage who choose not to purchase it will face financial penalties. The OHPC proposes that non-participants lose their individual exemption on state taxes and perhaps forfeit their kicker. Implementation of enforcement measures must be carefully planned to provide adequate time for Oregonians to understand their new personal responsibility to seek out insurance and enroll in available plans.

Care for Remaining Uninsured
Although the goal is 100 percent coverage, the OHPC recognizes that individuals at times will lack coverage for a variety of reasons. Those entering and leaving the state, changing jobs or undergoing a variety of life changes may temporarily be without coverage. Some people, such as the mentally ill and chronically homeless, may not be in a position to obtain and utilize health insurance. In addition, uninsured visitors to the state may need emergency care.

To ensure access to care for the uninsured and vulnerable populations facing significant financial, geographic, language, cultural, and other barriers to care, we must continue to develop a strong safety net. Local providers serving low-income and uninsured individuals offer culturally appropriate, trusted services. Recommendation #7 outlines some ways that Oregon can support local efforts to deliver health care more effectively and efficiently to all a community's residents.

[24] Oregon Revised Statutes 735.720.

Recommendation #4: Offer Low-Income Oregonians Publicly-Financed Support to Ensure Insurance Is Affordable

Proposal Overview

The Oregon Health Policy Commission (OHPC) recommends pairing an individual coverage mandate (Recommendation #3) with publicly-financed assistance that would make coverage affordable for individuals and families with incomes up to 300% of the Federal Poverty Level (FPL).[25] The goal is to ensure that everyone can afford the coverage that all Oregonians will be required to attain.

Publicly subsidized insurance would come in two forms: direct Medicaid coverage (the current Oregon Health Plan) and insurance premium assistance. The OHPC recommends a structure in which direct Medicaid coverage is an option for all children with family income up to 200% FPL, and adults up to 200% FPL who lack access to employer sponsored insurance. Adults with access to employer coverage and everyone with income between 200% and 300% FPL will utilize premium subsidies. These premium subsidies could be used to purchase insurance in the employer or individual markets.[26]

Subsidies will be graduated based on income and an affordability standard created by the Health Insurance Exchange (Recommendation #2), phasing out by 300% FPL. The Exchange would also act as a one-stop shop for Oregonians seeking out coverage options, serving as a connection point between individuals, coverage options, and public subsidies.

In order to most efficiently utilize state resources, the OHPC recommends maximizing federal Medicaid match to the highest income level that the federal government will approve. Under the Medicaid program, state dollars are matched with Federal funds, reimbursing the state 60 cents for every Medicaid dollar spent. Based on recent federal demonstration approvals for Massachusetts, Oregon should be able to receive federal Medicaid matching payments for much of the cost of a coverage expansion to 300% FPL.[27]

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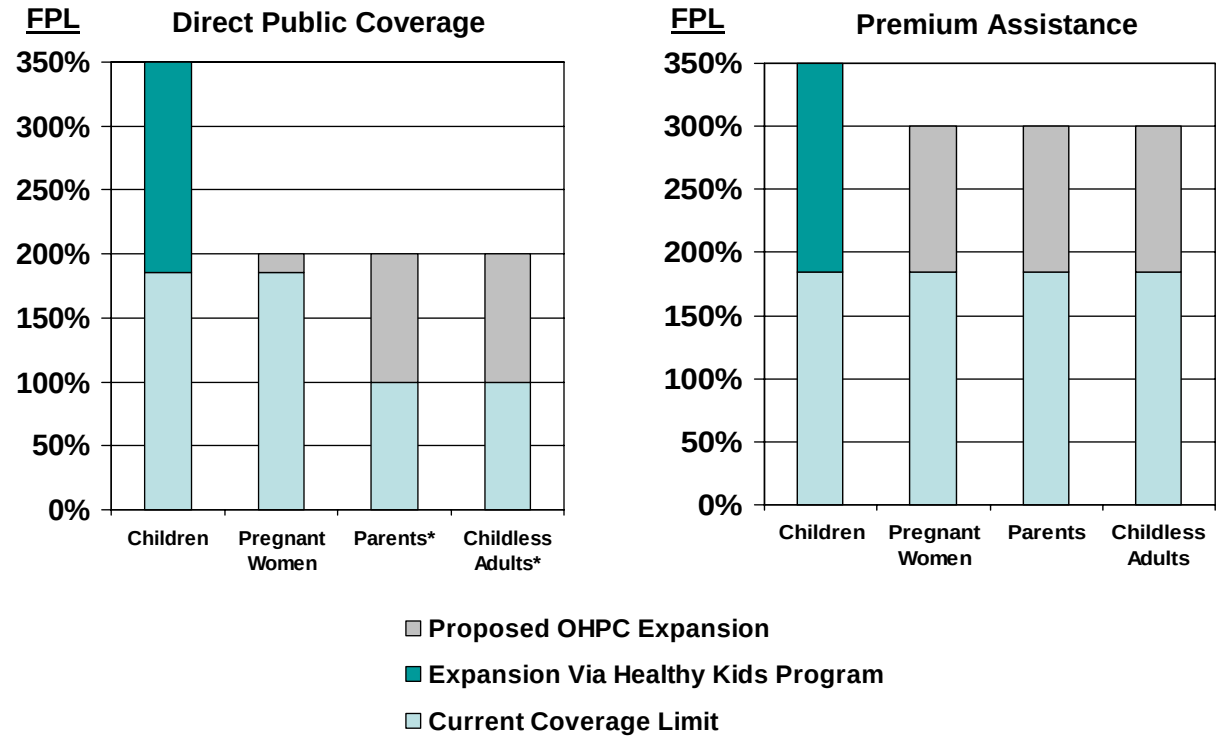
[25] In 2006, 300% of the Federal Poverty Level was $29,400 per year for an individual and $49,800 per year for a family of three.

[26] The OHPC recommends maintaining the coverage currently available for populations that are "categorically" eligible under federal Medicaid law, including children, pregnant women, elderly, and people with disabilities.

[27] Recent Medicaid waiver amendments approved by the federal Centers for Medicare and Medicaid Services for Massachusetts granted federal matching funds up to 300% FPL for premium subsidies for employer-based insurance. Up until this approval, it has been the policy of the Bush Administration to only approve federal matching funds for coverage expansions up to 200% FPL.

Overview of OHPC Proposed Expansion of Publicly-funded Coverage Options



*Note: Funding for OHP Standard currently limits enrollment to approximately 24,000 individuals.

Why Change Is Needed

An individual insurance mandate is only meaningful if all Oregonians have access to affordable coverage. In a survey of adults aged 18 and over, seventy percent of uninsured adults say the cost of insurance is the main reason they are without coverage, while only 6% say they are uninsured because they do not think they need it.[28] With 15.6% of Oregonians lacking health insurance coverage, insurance is prohibitively expensive for many in the state.[29]

The OHPC used the Economic Policy Institute's Family Budget Calculator which estimates necessary household expenses such as housing and food to develop recommendations on the income level at which people require assistance to make health insurance affordable. These data indicate that families do not begin to have discretionary income above necessary household expenses and household savings until they approach 250-300% of poverty. Based on this preliminary analysis, the OHPC recognizes that Oregonians up to 300% FPL require some assistance to make health care affordable.

[28] The *USA Today*/Kaiser Family Foundation/Harvard School of Public Health, "Health Care Costs Survey" August 2005.
[29] 2006 Oregon Population Survey.

Although 60% of Oregon employers offer health insurance to their full-time employees, a significant number of working people are not offered employer-sponsored insurance or cannot afford to purchase it. This is a particular problem for low-income individuals, for whom health insurance is often not offered as compensation for part-time and low-skilled employment.

Selected Implementation Considerations

Potential Negative Market Effects of Public Coverage Expansions
Encouraging employers to financially contribute to their employees' health insurance is essential to an affordable system where everyone contributes to the costs. One often cited concern with public coverage expansions is that employers may drop coverage if their employees become eligible for public coverage. Conversely, employees may decline employer insurance if public coverage is available, increasing public subsidy costs. To mitigate such issues, efforts must be undertaken to maintain employer participation in health care. Oregon could learn from the experience of other states' efforts to address these concerns in their public coverage expansions.

Publicly-Subsidized Insurance Can Push for Quality Coverage
The state has a responsibility to ensure that public health care funds purchase high quality, cost effective health care to promote a healthy Oregon. To that end, the state is currently investigating changes to the OHP Prioritized List of Health Services that will emphasize prevention, primary care and the proper management of chronic care.[30]

Another way the state can use its payer role to be a smart buyer is to require subsidies be used to purchase quality health coverage that promotes access to primary care, prevention, and chronic care management. To that end, individuals who access state subsidies to offset premium costs will purchase insurance products that promote preventive and primary care services.

[30] The Health Services Commission ranks health services by priority, from the most important to the least important, representing the comparative benefits of each service to the entire population to be served. In order to encourage effective and efficient medical evaluation and treatment, the Commission uses peer-reviewed medical literature to determine both the clinical effectiveness and cost-effectiveness of health services, and their relative importance. The Commission may also include clinical practice guidelines in its prioritized list of services.

Recommendation #5: Drive public and private stakeholders to continuously improve quality, safety, and efficiency to reduce costs and improve health outcomes

The Oregon Health Policy Commission believes that true reform is more than just assuring access to health care. It also requires the creation of a high-value health care system that:

- *Provides high quality, safe care* that is organized, coordinated, and integrated across providers and over the life of the individual;
- *Ensures evidence-based care* that provides the right care at the right time and setting in a cost-efficient manner; and
- *Supports continuous improvement* through information transparency, reliable health information exchange, adequate workforce development and a culture of improvement.

Everyone must participate to achieve change. To achieve a high-value health system, the OHPC, along with numerous national and state level policy organizations, supports bringing the state, providers, purchasers, and individuals together to push the system forward in some key areas:

- Improving information collection, reporting, and outcomes measurement;
- Improving the system's ability to manage for quality and become more transparent;
- Encouraging public-private collaboration on value-based purchasing;
- Developing widespread and shared electronic health records;
- Assuring a well-trained health care workforce; and
- Increasing health care safety.

This section outlines some concrete reforms Oregon can implement now to create a health care system that continually improves quality, safety, and efficiency to reduce costs and improve outcomes. The OHPC acknowledges the efforts of the Commission's Quality and Transparency Workgroup in developing these recommendations.

Overview of Proposals

Make targeted state investments

The OHPC supports the use of targeted state investments to achieve increases in health care quality, efficiency and value. The OHPC encourages the Governor and the Oregon Legislature to include such investments in the 2007-2009 state budget. A variety of organizations and efforts would benefit greatly from small investments in state staff and funding, as state involvement would help assure more rapid progress with the following:

- The success of the Oregon Patient Safety Commission's mission;
- The improvement of data available for managing the system;
- Increased transparency regarding health system performance; and

- The coordination of efforts to expand electronic health records and connect health information across providers.

Create the collaborative structure to improve quality information collection, measurement, and reporting

Building on current collaborations among private organizations and the Office for Oregon Health Policy and Research (OHPR), the OHPC recommends that the Oregon Legislature direct OHPR to work with stakeholders to develop a model for a public-private quality institute. The purpose of this institute would be to coordinate the creation, collection and reporting of quality information to improve health care purchasing and delivery. An independent public-private entity is critical for gaining the trust of all key stakeholders. The institute should be financially stable and make efficient use of available public and private funds. An organized, stable structure will help Oregon attract additional resources from federal and private funders.

Responsibilities of a quality institute would include:

- Collecting quality data and information in a central location;
- Coordinating reporting of quality information from numerous sources in a central location;
- Complementing individual stakeholder efforts;
- Supporting and encouraging collaboration between quality efforts in the state;
- Examining state regulations for opportunities to increase efficiency and reduce administrative complexity;
- Addressing issues of legal discovery and liability;
- Fostering provider capacity to collect and use data for improvement;
- Encouraging dissemination of data in formats that are useful to a broad range of audiences; and
- Engaging Oregonians to use available quality data when choosing health care providers.

Encourage all purchasers, providers, and state agencies to further develop data and tools to improve system transparency and quality

The OHPC encourages all purchasers, providers, and state agencies to support and expand on current public-private efforts to improve data and tools to manage quality and to improve data available to the providers and consumers:

- Hospital quality including: participation in efforts such as the Surgical Care Improvement Project (SCIP), the National Surgical Quality Improvement Program (NSQIP), 100,000 Lives, and Leapfrog reporting in addition to state and federal mandated reporting;
- Hospital cost reporting;
- Ambulatory care quality measures;
- Actual cost of service reporting, including cost of services provided in Oregon Health Plan Medicaid managed care plans;
- HEDIS and HEDIS-like quality measures; and

- Collaborative public/private strategies to make consumers more knowledgeable about quality and value in health care and the resources available to them.

Encourage increased public-private collaboration to create stronger, more coordinated statewide value-based purchasing

The State should strongly encourage value-based purchasing. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) and health care entities (providers, health plans) to improve quality, efficiency, and outcomes. The Public Employees Benefit Board (PEBB) should have a strong role in such a coordinated effort, along with the Department of Human Services, the Oregon Medical Insurance Pool (OMIP), university health, the SAIF Corporation and the Department of Corrections. Collaboration with other private and public purchasers to develop a consistent value-based purchasing approach in the community is an important part of this effort.

Through this coordinated effort, state agencies should implement the following reforms:

- **Ensure state health care purchasers use purchasing standards that explicitly include quality measures in the criteria for selecting which health plan options to offer.** PEBB could provide leadership in this arena, as it currently does this in its biennial Request for Proposals to health plans.

- **Collect information on quality performance regularly and rigorously and distribute this information widely to help employees and their dependents make informed choices among health plans and providers.** PEBB has established a comprehensive set of performance measurements for its health plans and is participating in community efforts to identify common measures for evidence-based care.

- **Offer state employees information and incentives to choose high-value health plans and providers.** Medicaid should also consider how best to provide value information to its enrollees.

- **Reinstitute prior authorization to manage access to Medicaid pharmaceuticals.** Utilizing prior authorization to enforce the Prioritized List has great potential for cost savings.[31] This requires statutory change, as prior authorization for the Oregon Health Plan preferred drug list is currently prohibited by statute.

- **Improve the Oregon Health Plan's access to technology.** The Department of Human Services has the opportunity to manage the prudent use of technology in its Medicaid program. Line zero of the Prioritized List (the line that covers diagnostic services) can be managed by incorporating evidence-based reimbursement and/or prior authorization. At the

[31] "An Evaluation of Oregon's Evidence-Based Practitioner-Managed Prescription Drug Plan," Daniel M. Hartung, et al., *Health Affairs*, 25, no. 5 (2006): 1423-1432**.**

printing of this report, this idea is under discussion by the Oregon Health Services Commission, the group that oversees the Prioritized List.

- **Expand disease management programs under the Oregon Health Plan.** Currently the OHP disease management program targets five key chronic conditions: asthma; chronic obstructive pulmonary disease; coronary artery disease; diabetes; and heart failure. This program helps individuals with chronic conditions manage their care by providing patients with the most cost effective services and health practices for their conditions.

- **Continue to maximize efforts to increase access to prescription drugs by the uninsured.** The state is currently seeking to access the power of bulk purchasing through the Oregon Prescription Drug Program (OPDP). The OPDP increases the uninsured's access to prescription drugs, and lowers state and city government costs while helping them stay within budgeted goals. The program can leverage the best prices on the most effective medicines by pooling prescription drug purchasing power, using evidence-based research to develop a preferred list of lowest cost drugs, and negotiating competitive discounts with pharmacies. In 2006, the OPDP and Washington's Prescription Drug Program formed the Northwest Prescription Drug Consortium. The Consortium has a potential enrollment pool of over five million members. That negotiating strength helped negotiate a new administrative contract with The ODS Companies that brings greater economic value, auditable transparency and financially guaranteed service levels for both group and uninsured members. This contract makes the OPDP and WPDP competitive in their markets for group participation and brings unprecedented value for their uninsured populations.

Develop widespread and shared electronic health records (EHR)

- **Increase coordination.** The state should fund a state coordinator of Health Information on a continuing basis with sufficient staff and funding support to carry out the assigned functions. The coordinator provides a strong state leadership role for health information exchange and EHR adoption, assures coordination of community efforts throughout Oregon, and assures that Oregon health records are compatible with emerging national standards and infrastructure. Among other things, the coordinator should conduct an ongoing assessment of the costs and benefits of implementing electronic health records and health information exchange for Oregon as a whole.

- **Create pilot programs for health information exchange.** The state should solicit CMS and other funding to support pilot projects that encourage health information exchange and reduce silos of personal health information. Examples of such projects are: (a) an Oregon Business Council funded Oregon Health Care Quality Corporation effort to develop a Portland metropolitan area pilot project for viewing and retrieval of lab results, image reports and hospital and emergency department summaries; and (b) a statewide master patient index to enhance the potential for information sharing.

- **Support efforts to improve privacy and security of electronic health records.** The state should support implementation and dissemination of the Health Information Security and Privacy Collaborative recommendations released in Spring 2007.[32] These recommendations outline several steps that foster the protection of patients' health information especially in an electronic exchange. The plan looks at the public and private sector roles with regard to identification, authentication and authorization of users, addressing medical identity theft, reviewing specially protected information laws, educating consumers, protecting health information held by non-covered entities, ensuring appropriate access for secondary use, and enforcing current law. The report suggests the need for funded coordination at the state level through a Health Information Privacy Coordinator, as well as technical assistance to organizations for comprehensive adoption of appropriate privacy and security practices. In phase two of the project, the Collaborative intends to develop a "communication toolkit" to improve consumer education on health information exchange.

- **Monitor and promote widespread adoption of electronic health records.** The state should perform an annual assessment of EHR adoption to guide policy and identify areas where targeted assistance is needed. To the extent that small practices and safety net clinics are unable to finance timely EHR implementation, the state should help them secure other funding to do so, including federal sources such as CMS. Coordinated value-based purchasing activities should promote the creation of incentives for EHR adoption, including payment scenarios that allow some financial benefit to accrue to a provider investing in EHR.

- **Promote claims processing efficiencies.** The state should continue its efforts to create a simplified and standardized claims processing system throughout Oregon, using its influence as a purchaser and as the regulator of many of the key players. This would reduce the impact of inefficient claims processing and high transaction costs on the costs of health care, allowing funds to be better spent elsewhere. It is likely that this claims processing system can be integrated over time with EHRs and HIEs, such that health information is fully integrated.

Assure a workforce that can capitalize on health information technology

Sufficient provider capacity is necessary for successful system reform. Creative efforts will have to be undertaken to expand capacity and increase provider education in order to meet a range of patient needs and to successfully use information technology in health care settings.

It is important to train current and new providers in electronic record keeping. The OHPC recommends the Workforce Institute train practitioners who can capitalize on new information technology. Increased use of technology will result in improved, better coordinated care that will minimize duplication and errors. For advances in health information technology to be meaningfully translated into improved patient care, providers must both understand the value of

[32] The implementation plan of the Health Information Security and Privacy Collaborative *Privacy and Security Solutions for Interoperable Health Information Exchange* can be found at: http://www.q-corp.org/q-corp/images/public/pdfs/final_implementation_plan_report.pdf

using technology (such as electronic medical records) and be comfortable using the technology. As technology changes, health care staff from nurses and physicians to medical office and hospital staff need training to remain current in their knowledge.

Increase collaboration and state leadership to improve health care safety

The OHPC recommends further developing the work of the Oregon Patient Safety Commission in order to:

- Encourage the participation of all hospitals, nursing homes, ambulatory surgery centers, retail pharmacies and other health care facilities in the Oregon Patient Safety Commission's voluntary reporting program of serious adverse events.
- Incorporate a surgical events reporting program (specifically, the National Surgical Quality Improvement Program) within the Patient Safety Commission to encourage cross-institutional sharing and learning. The OHPC recognizes that implementation of this recommendation requires finding a way for rural hospitals to be financially able to participate. Direct OHPR to establish public reporting of quality measures at the institutional level.
- Provide state financial support for the Oregon Patient Safety Commission's work in order to give the Commission the means to build awareness of and to develop strategies to reduce serious adverse events and their costs.

Why These Reforms Are Needed

Information, Measurement, Collaboration Are Key to Quality Care
Numerous public and private efforts are underway to push for improvements in quality, transparency, and coordination of care. Many of these efforts will be more effective if accomplished collaboratively between public and private entities. Involving more provider and payer organizations in the data collection process improves the quality of information provided and increases providers' and insurers' interest in using the information collected to improve care quality and efficiency.

For example, quality information on evidence-based care becomes more valid and useful to providers when data is consolidated across the community rather than by individual health plan. An excellent example of the power of a collaborative public-private approach is the recent Oregon Health Care Quality Corporation's leadership in developing common measures of ambulatory care and the strategic plan for market-driven change supported by a Robert Wood Johnson Foundation grant. This grant is, however, only a three year project, leaving the funding for continuation and enhancement unknown at this time.

There is a need for a stable model to continue such efforts into the future and consolidate a variety of information beyond the limited scope of the Robert Wood Johnson grant. Public and private interests should explore the model most likely to provide stability for the critical function of providing a range of quality information to a range of users. The answer could come in

strengthening existing organizations, new collaborations, or new institutions meeting basic functions detailed in the recommendation.

Information Transparency Will Improve the System's Ability to Manage for Quality
The OHPC continues to recognize and support the need for performance information to guide purchasers, providers, and consumers in their efforts to make wise decisions, spend resources wisely and perhaps most importantly, improve performance. Experience has shown that publicly available information can result in both improved performance and in more focused attention to quality improvement efforts. Providers need to benchmark their performance, purchasers need ways to identify and reward quality performance, and consumers need information to help them make critical decisions.

Much of the value of public information to date has been to promote quality in the provider community itself. Consumers need to be more aware of why they need to care about health care quality and information that will help them make wise personal health decisions. Major health plans are becoming both more concerned and in many cases are making significant investments to offer more tools to consumers and employers. Consumer organizations are increasingly interested in promoting a more active and aware consumer. The state should participate in collaborative efforts such as the Robert Wood Johnson Foundation Grant program linking public and private organizations (including consumer organizations) in an effort to inform consumers about quality variations and to improve the tools available to help consumers seek quality in the delivery of their health care.

There are many efforts currently at the national and state level to improve quality information and to make information transparent. Often, however, these efforts are not coordinated. One of the positive national trends is for the major federal purchasers (Centers for Medicare and Medicaid Services) and quality organizations (Agency for Healthcare Research and Quality) to collaborate with important professional organizations (such as the College of Surgeons and the Joint Commission for the Accreditation of Health Organizations) and private non-profit entities such as the Institute for Healthcare Improvement and the Leapfrog Group for Patient Safety. This has resulted in new programs and strategies such as the Surgical Care Improvement Program, the 100,000 Lives Initiative, the National Surgery Quality Improvement Program, and payment increases being tied to increased quality reporting by hospitals to CMS. Many of these efforts improve data transparency. For example, the CMS Hospital Compare program or the State of Oregon website that provides mortality data for 8 procedures and volume data for 7. Some efforts are not fully transparent, but are associated with significant quality improvement tools designed to help organizations address the issues that data identifies such as NSQIP and 100,000 Lives.

Public/Private Collaboration Is Needed to Promote Value-Based Purchasing
The OHPC supports an expansion of purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost. Value-based purchasing strategies seek to influence the decisions or behavior of individuals (employees, patients) or health care entities (providers, health plans).

The state can and should take a strong lead in pushing health care purchasers to develop value-based purchasing strategies statewide. The Public Employees Benefit Board (PEBB) is a leader in value-based purchasing in Oregon. PEBB designs, contracts and administers a range of insurance products and flexible spending accounts for state employees and their dependents. It also offers health insurance options to retirees not yet eligible for Medicare and individuals in other participating groups. PEBB's total membership is approximately 120,000 individuals.

There is great potential for value-based purchasing strategies within Oregon's Medicaid program, which has over 270,000 enrollees in managed care and approximately 70,000 others in fee-for-service or primary care case management. This enrollment gives Medicaid both leverage and opportunity to influence the quality of care for its enrollees and the broader community. It also represents a large portion of the state's budget, giving efforts to improve service efficiency and quality broad implications.

Widespread, Shared Electronic Health Records Will Improve Care Quality and Efficiency
Good health information is key to the development of a high-value health care system. Reliable health information exchange (HIE) makes patient information available when and where it is needed to all who are authorized to access it. A recent study by the Commonwealth Fund ranked the United States last compared to four other developed countries with regard to the availability of health records when needed and regarding redundant medical testing. A robust system of interoperable electronic health records (EHR) can reduce duplicative medical tests by 15-20%. Evidence shows that EHRs that include tools such as clinical decision support, reminders and registries helps better manage patient care and improves quality.

Investments in EHR and HIE have substantial economic benefits to society as a whole, measured by improved outcomes, fewer mistakes, more effective, efficient and timely treatment, and reduced transaction costs. Among other things, EHRs can reduce billing errors and prevent fraud through improved documentation and administrative checklists, benefiting both providers and society.

The costs are sometimes cited as a reason providers are hesitant to invest in EHR, but recent research suggests that the costs of implementation are quickly recovered. Researchers at the University of California, San Francisco conducted case studies of solo and small primary care practices using EHR.[33] They found average start up costs of $44,000 per provider, with practices recouping the investment costs in two and a half years. The average annual efficiency savings and benefits of increased provider productivity was $15,800 per provider per year.

In a March 2005 Report to the 73rd Oregon Legislative Assembly, a subcommittee of the Oregon Health Policy Commission recommended that the state take reasonable steps to promote the rapid and widespread adoption of health information technology including electronic health records and health information exchanges. It is now 2007, and the reasons for bringing modern information technology to Oregon health care are still compelling. While some progress has been made since the 2005 report, there is much yet to be done.

[33] "The Value of Electronic Health records in Solo or Small Group Practices" Robert. H. Miller, et al., *Health Affairs,* September/October 2005, 24 (5): 1127–3.

Widespread adoption of compatible and shareable information technology is essential for improving the quality and safety of care and reducing waste and costs. A functioning EHR system:

- Provides improved manageability of health data;
- Offers support for provider decisions at the point of care, such as reminders and alerts about drug interactions;
- Allows for electronic prescribing and order entry by providers, thus reducing mistakes secondary to legibility, improving communication, providing interaction checking and increasing efficiency of the refill process and formulary adherence
- Facilitates patient population reporting and management;
- Can improve the productivity of health care staff over time;
- Facilitates the delivery of evidence-based health care; and
- Improves the coordination of care for the chronically ill (the highest users of health care.)

Oregon Needs a Well-Trained Health Care Workforce

The OHPC sees the newly formed Oregon Health Care Workforce Institute as an integral component of health care system reform. The Institute is a private-public partnership charged with developing a coordinated statewide response to critical needs in the health care workforce. The Institute will provide consistent and reliable research about health care workforce shortages and develop policies and resources to resolve the shortage. To minimize duplication and errors, it is critical that workforce training focus on building the understanding and skills to capitalize on new information technology that will result in improved, better coordinated care.

Improving Health Care Safety Will Decrease Costs and Improve Health Outcomes

Health care leaders agree that medical errors represent an epidemic that is beatable. The Institute of Medicine found that 44,000 to 98,000 people die in hospitals each year as the result of such events. The federal Veterans Administration system reports that about 180,000 deaths occur each year in the United States from "errors in medical care" across all health care settings. Other studies place the number of deaths even higher. In addition to deaths, many adverse events lead to serious, but non-fatal injuries. A recent survey of physicians and of the public offers a different perspective but with similar intent—35 percent of practicing physicians and 42 percent of the public have experienced a preventable medical error either personally or within their families. In Oregon, even with a health care system continually working to improve quality, more people probably die as the result of adverse events than from diabetes, Alzheimer's, or pneumonia. Research findings consistently indicate that 50 to 70 percent of errors are preventable—if systems issues are identified and corrected.

The Oregon Patient Safety Commission was created during the 2003 legislative session to reduce the risk of adverse events and to encourage a culture of safety in Oregon's health care system. The Commission brings a much needed independent view to quality issues and patient safety remedies. And while this Commission has made great strides in 2006 – 52 hospitals in Oregon are voluntarily reporting adverse events – currently the Commission is funded solely through fees from the hospitals. State financial support is needed in order to expand the Commission's role and impact.

Recommendation #6: Support Community Efforts to Improve Health Care Access and Delivery

The Oregon Health Policy Commission (OHPC) recognizes that no one service delivery model will assure access for all people, communities, or providers. Health care delivery is local. Reform approaches need to be flexible enough to provide local communities the ability to tailor their local systems to the needs and characteristics of their community. There are two community responses to local health care needs that the Commission believes requires the urgent attention and involvement of the state, businesses, insurers, and community members alike – the health care safety net and local community health care access collaboratives.

The following are recommendations submitted to the Commission from the Safety Net Advisory Council and the OHPC Local Delivery System workgroup that the Commission supports to further local innovation in health care delivery.[34]

Overview of Proposals

Promote the primary care home model

The OHPC recommends creating a pilot grant program to support community efforts to provide Oregonians with a primary care medical "home" where they can receive timely, affordable, and comprehensive care. The OHPC believes this will enhance quality and reduce cost for vulnerable Oregonians.

Successful applicants will need to demonstrate a measurable short-term impact on cost and health outcomes, particularly for patients with chronic conditions, and a longer-term impact on patient health through preventive services. Successful applicants will have a demonstrated commitment to serve uninsured and Medicaid patients and collaborate with the broader healthcare system. Primary care home components to be supported through grants would include building the provider-patient relationships, comprehensive and integrated care, and assist patients with health system navigation and coordination.

Support local access collaboratives

The OHPC supports legislation establishing a state matching grant program to support development of local access collaboratives. The Community must demonstrate that the project is collaborative (public/private partnerships). Possible parameters for projects include:

- Increasing capacity and/or access;
- Coordinating the process of delivering comprehensive health care services;

[34] See Appendix A for a list of Safety Net Advisory Council and Delivery System Workgroup members.

- Aligning available resources and leveraging financial commitments from stakeholders;
- Engaging multiple, diverse, public and private stakeholders;
- Sharing the risks and rewards across stakeholders;
- Offering significant stability to the local health care system;
- Reducing health disparities and increasing efficiencies and savings;
- Promoting the development of information technology infrastructure; and
- Promoting a continuum of care.

Include safety net providers and local community collaboratives in initiatives to realign payment incentives

The OHPC believes that reforming how our health care system pays for services is key to system reform. The OHPC will to embark on a thoughtful planning process to develop a collaborative initiative which will drive reimbursement reform forward in Oregon (See Section on "Priority Policies for Further Development by OHPC"). Payment reform must provide incentives for cost-effective care that improves health outcomes, as well as fuel the development of electronic health records, data sharing, and reporting systems. Safety net providers and the local community collaboratives should be at the table for this discussion to ensure that reforms support local innovation in providing high-value health care.

Why These Reforms Are Needed

The Health Care Safety Net

The health care safety net is a community's response to the needs of people who experience barriers to appropriate, timely, affordable and continuous health services. Health care safety net providers include a broad range of local non-profit organizations, government agencies, hospitals, and individual providers. Core safety net providers are a subset of the larger safety net and are especially adept at serving people who experience significant barriers to care, including homelessness, cultural and language barriers, geographic and social isolation, mental illness, substance abuse, cognitive impairment, decreased functional status, health literacy barriers, financial barriers, lack of insurance or undersinsurnace and other barriers. . These providers have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need.

The Health Care Safety Net Advisory Council (SNAC) was created in 2005 as an advisory body that promotes understanding and support for safety net patients and providers in Oregon. SNAC provides the Governor and the Oregon Health Policy Commission with specific policy recommendations for safety net providers in order to ensure the provision of needed health services to vulnerable Oregonians.

Community Health Care Access Collaboratives

Throughout 2005 and 2006, the Commission convened the Local Delivery Systems Workgroup to bring together experts from throughout Oregon to investigate what can be done to support local or "community-created" solutions to improving access to health care within Oregon communities. Nineteen of Oregon's 36 counties are designing and implementing local solutions that ensure access to timely, quality, and affordable services delivered in an effective, efficient and sustainable manner. In order to promote the health of an entire community, these local health system collaborative efforts are working to:

- Coordinate comprehensive health services;
- Offer stability and accountability;
- Leverage existing dollars;
- Involve multiple, diverse, public and private sector stakeholders;
- Require local leadership or champions;
- Share risks and rewards.

The Commission released a report prepared by the workgroup in January 2006 highlighting ways the state could support these community efforts including recognizing the importance of the efforts, facilitating information sharing between communities, and creating flexible state policies to permit local delivery system redesign.[35]

[35] The OHPC Local Delivery Systems Workgroup report on community collaboratives is on the OHPC website at: http://www.oregon.gov/DAS/OHPPR/HPC/docs/2006/SurveyofCommunityCreatedHealthcareSolutionsinOregon06.pdf

Recommendation #7: Establish Sustainable and Equitable Financing for Reform

Proposal Overview

Health care reform requires improvements on multiple fronts: the uninsured must gain coverage and the provision of services must be made more efficient and less costly. While many people agree that there are sufficient resources in the system to fund care for everyone, the difficult part is capturing and distributing the funding where it is needed. Rather than waiting for system reforms to be implemented before bringing the uninsured into the system, the Oregon Health Policy Commission (OHPC) proposes working toward both universal coverage and improved system efficiency simultaneously. To fund coverage expansion and premium subsidies for low-income uninsured Oregonians, the OHPC proposes up-front funding that will be phased out as system efficiencies take hold over the following years.

Preliminary pricing of the OHPC reform plan indicate that approximately $550 million per year is needed initially to finance the public coverage and premium subsidies structure proposed in this report.[36] This upfront investment in Oregonians' health will produce savings throughout the state. This investment, to be implemented along with delivery system and other reforms, will lead to more productive employees, improved outcomes, and reductions in system costs.

The OHPC recognizes that to implement the OHPC plan, a funding source will need to be identified. The OHPC recommends consideration of financing scenarios that are broad-based, stable, and ensure that everyone contributes to system reform. The OHPC also recognizes that many employers currently provide insurance to their employees. These employers are already subsidizing the system and should be rewarded for their ongoing contribution. To recognize this participation, financing sources involving employers should equalize the financial burden between employers that provide health coverage to employees and those that do not.

Table 1 includes initial estimates of various payroll tax and employer fee scenarios that could fund the necessary revenue of $550 million per year; and Table 2 provides some other revenue sources that may be proposed during reform discussions.

[36] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at: http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
The actual cost may be less or more, depending on a number of factors included in the modeling, such as whether an asset test or waiting period are required for public coverage and subsidies, and extent of crowd out into public programs.

Why This Change Is Needed

Universal Coverage Reduces Burden of Cost Shift

The current system funds care for the uninsured primarily through higher premiums for the insured. Providers pass the costs of caring for the uninsured on to insurers. The insured and employers that offer insurance pay more, as insurers pass on their increased costs to members. With universal health insurance in Oregon, providers will experience great reductions in "uncompensated" care. This will allow them to charge the insured for the actual cost of their care. Premiums should be adjusted in response. The insured will pay premiums that reflect a truer cost of providing care.

An Initial Investment Will Pay Off in the Future

Oregon bears a heavy cost for having a large uninsured population. The estimated cost of hospital uncompensated care was $299 million in 2004, and that number continues to increase. Researchers estimate that total uncompensated care (hospital, physician and out of hospital care) will be $534 million in 2008.[37] Both state government and the insured pay for this care. Uncompensated care accounts for ten percent of the cost of insurance premiums.

As the Institute of Medicine noted in its 2003 report, these costs are not just due to the costs of providing free health services to persons without insurance coverage.[38] Much of the cost is due to the poorer health experienced by the uninsured, who receive too little care. The economic value of better health outcomes that would accrue from continuous health insurance coverage (and appropriate health care use) for all Americans is between $65 and $130 billion a year.[39] The savings include higher expected lifetime earnings and educational and developmental outcomes.

System savings will accrue through reductions in uncompensated care costs and improvements that ensure people are getting the right care at the right time. However, as outlined in this report, to reap the benefits of an insurance market that covers everyone in the state, Oregon must implement a system of publicly financed subsidies that facilitate access to affordable insurance.

An investment in universal insurance coverage will reap the greatest gains if change is paired with delivery system reforms that make the system more efficient and accountable. The following are a few delivery system improvements that can control costs and improve care.

- Small practices that implement electronic health records recoup their initial investments in technology and training in an average of 30 months.[40]
- Reducing hospital acquired infections could reduce the rate of increase in insurance premiums and help make coverage more affordable. The average hospital stay was $32,000 higher when the patient experienced a hospital acquired infection (HAI).[41]

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[37] "Covering the Uninsured: The Cost to Oregon", John McConnell, et al., 2007. This companion report to the OHPC recommendation report is available at http://www.oregon.gov/DAS/OHPPR/HPC/Reports.shtml.
[38] *Hidden Costs, Value Lost: Uninsurance in America*, Institute of Medicine Committee on the Consequences of Uninsurance. 2003.
[39] Wilhelmine Miller, et al., op cit.
[40] H. Miller, et al., op cit.

- Medication errors are expensive and can be costly in terms of health outcomes. The Institute of Medicine estimated there are 7,000 deaths annually due to medication errors.[42] Each preventable adverse drug event added $2,000 to the cost of hospitalization, totaling $2 billion nationally in hospital care costs. The cost of medication errors is likely even higher, as drug errors and other problems arising from lack of medication reconciliation exist in other settings, including at nursing facilities, physician offices and medical clinics.

Everyone Must Contribute to Reform
Health care is a shared social responsibility and that everyone should contribute to health insurance coverage. Many employers are doing their share and more, subsidizing care for the uninsured through higher premium payments. New financing considerations should recognize these contributions and help equalize the burden of health insurance costs across employers.

Sustainable Reform Requires Sustainable Financing
Reform requires a stable funding source. A broad-based employment payroll assessment is one sustainable funding option that can be used to finance public coverage. Whether such a tax or fee is paid only by employers or is shared by employers and employees, such a source would ensure a stable funding base to which everyone contributes.

Implementation Consideration

ERISA and the Structure of an Employer Assessment
Table 1 outlines various options for a payroll assessment. If a payroll tax or fee is considered, the OHPC recommends a structure where employers who offer insurance are allowed to recoup all or a portion of the assessment paid.

The OHPC does not recommend a specified level of coverage in order for an employer to be eligible for a tax benefit provision. Any such requirement would likely face legal challenge under the Employee Retirement Income Security Act (ERISA). ERISA substantially limits states' ability to regulate employee benefit plans, including health insurance. While a state employer health insurance mandate has not received full legal vetting, recent court rulings indicate that states might be vulnerable to legal challenges if they attempt to require employers to provide a certain level of health insurance.[43] ERISA poses a serious implementation issue that must be considered in the design of a reform plan. Appendix D includes some guidelines provided by the National Academy for State Health Policy.

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[41]"Infections Due to medical Care in Oregon Hospitals, 2003-2005" Research Brief by Office for Oregon Health Policy & Research. November 2006. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/.
[42] "To Err Is Human: Building a Safer Health System," Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, Editors, Institute o f Medicine. National Academy Press, 2000.
[43] On July 19, 2006, U.S. District Judge J. Frederick Motz overturned Maryland's Fair Share Health Care law, which had required large employers to spend at least 8 percent of their payroll on health care for employees or pay the equivalent in fees to the state. The judge's decision noted that the federal ERISA law preempted the Maryland law. .Judge Motz's rule is available at <http://www.mdd.uscourts.gov/Opinions152/Opinions/Walmartopinion.pdf>.

Table 1. Various Payroll Assessment Scenarios to Fund OHPC Proposed Public Coverage Expansion
Estimated Initial Direct Public Investment: $550 million per year

INITIAL ESTIMATES - FOR ILLUSTRATION ONLY

	Assessment Scenario	Approx. Assessment % required to raise revenue		Average Annual Payment Per Employee			
				2007	2008	2009	2010
a)	• Employer financed payroll assessment • No employer credit for offering insurance	0.8%	Employer share	$320	$320	$330	$350
b)	• Employer & employee financed payroll assessment (50/50) • No employer credit for offering insurance	0.8%	Employer share	$160	$160	$165	$175
			Employee share	$160	$160	$165	$175
c)	• Employer financed payroll assessment • Full employer credit for offering insurance	2.8%	Employer share (if offers insurance)	$0	$0	$0	$0
			Employer share (if no insurance offered)	$1,040	$1,040	$1,090	$1,150
d)	• Employer financed payroll assessment • Partial employer credit for offering insurance (50%)	1.25%	Employer share (please see table notes)	$1,070	$1,060	$1,120	$1,180
e)	• Employer financed payroll assessment • No employer credit for offering insurance • Additional surcharge per employee ($300/year) • Full credit for surcharge for employers offering insurance	0.6% + $300/yr if not offering insurance	Employer share (if offers insurance	$240	$240	$250	$260
			Employer share if (if no insurance offered)	$540	$540	$550	$560

Source: Preliminary revenue estimates, OHPC, January 2006. Based on public and private payroll estimates (see reference below).
Notes: Option B is included as illustration that assessments could be split between employers and employees. Options c, d, and e could also be jointly financed by employers and employees. Option D provides an estimate of the average payment per employee for all employers. Employers who provide insurance would pay less per employee as they would be eligible for the 50% tax credit. Employers who do not would pay more per employee.

REFERENCE:	**2007**	**2008**	**2009**	**2010**
Total Oregon Public & Private Payroll ($ in billions)	67.6	71.1	74.8	78.7
Total Number of Oregon Workers ($ in millions)	1.7	1.8	1.8	1.8

Source: Payroll and employment estimates, December 2004 Oregon Economic Forecast

Table 2. Additional Funding Options for Discussion

The following are some other funding sources that could be considered to finance the cost of proposed public insurance expansions.

Funding Source (in millions)[44]	FY 2007-08	FY 2008-09	Broad Tax	Targeted Tax
Broad Retail Sales Tax – 1% Rate (exempts shelter and groceries)	$860.2	$910.9	✓	
Restricted Retail Sales Tax – 1% rate (exempts shelter, groceries, public transport, health care, education, personal insurance, utilities, gasoline, tobacco products)	$607.2	$642.7	✓	✓
Increase Tobacco Tax – Increase Cigarette Tax by 84 cents per Pack[45]	$180-190	TBD	✓	✓
Increase Beer Tax – Increase Beer Tax by $1 per barrel	$2.6	$2.6		✓
Increase Wine Tax – Increase Wine Tax by 25 cents per gallon	$2.4	$2.4		✓
Medical luxury tax – Ex. 1% on cosmetic surgery not resulting from trauma or medical condition	TBD	TBD		✓
Provider Tax – Amount of tax depends on scope of provider types included	TBD	TBD		✓

[44] Information from 2006 Oregon Public Finance: Basic Facts, Research Report #1-06. Legislative Revenue Office. February 24, 2006. http://www.leg.state.or.us/comm/lro/home.htm.
[45] Tobacco tax data (per pack amount and total revenue for the 2007-2009 biennium) are from the Governor's recommended budget.

Recommendation #8: Design and Implement System Reform Evaluation

Health Care Reform Demands a Strong Evaluation Component

The Health Policy Commission recognizes evaluation is an integral component of any successful health reform package. The purpose of evaluation is to measure health care capacity and access and to determine whether policy changes are having the intended impact on access, quality, and health outcomes. The OHPC recommends that a coherent, stable and coordinated evaluation infrastructure be developed prior to implementation to assess success and inform future policy decisions. Oregon's research infrastructure can be formalized and expanded to evaluate any global reform efforts. Building on this infrastructure is cost-efficient and timely.

Components of the Evaluation Infrastructure

- A well-designed baseline evaluation plan, capturing the data necessary to demonstrate 'pre-post' changes and attribute changes to specific reform policies;
- An evaluation of reform implementation, ensuring that implemented programs and practices are in line with the intention of policies;
- Identified sustainable funding for on-going evaluation identified during passage of any reform legislation;
- A central entity responsible for:
  - Collecting statewide and community level data, with the authority to collect data from providers and other entities that is integral to successful reform evaluation;
  - Coordinating existing state and community resources to develop shared units of measurement and metrics of change;
  - Developing a dissemination protocol that would ensure policymakers receive evaluation results in a timely manner and understandable format in order to be useful;
  - Developing and maintaining an integrative and interactive website where communities and policymakers could access relevant local and state data to inform their programmatic, practice, and local policy approaches.

Recommended Metrics of Change

A health reform evaluation plan would develop metrics from the outcomes described below. Some of the metrics outlined below can be extracted from current national and state surveys. However, several metrics are not currently collected in a manner that would be representative of all demographic subsets of Oregonians, such as race/ethnicity and geographic location. An Oregon population survey related to health care would be needed and health care providers

would need to begin providing capacity data by insurance type, provider type, FTE, and clinic location.

- Provider and Consumer participation
  - Managed care participation
  - Use and usefulness of Health Insurance Exchange
  - Insurance status rates across demographic variables
- Provider capacity
  - By primary care and by specialty care
  - By clinic location
  - By provider type
  - By insurance type (e.g. Medicare, Medicaid)
- Population demand by age subgroups (e.g. pediatric care) and by disease subsets (e.g. chronic diseases)
- Utilization patterns that emphasize on preventative care and chronic disease management
  - Access to the appropriate level of care in a timely fashion:
    - Emergency Department visits by IC-9 codes
    - Number of primary care visits by age/demographic subsets
    - Appropriate use of diagnostic and specialty care
  - By insurance type (to assess impacts of co-pays and high-deductible plans)
- Changes in health outcomes and disparities, particularly members of vulnerable subgroups
- Health care quality measures
- Financial impacts that reflect affordability for the state, providers, employers, individuals and families
- Special concerns such as "crowd-out", effective and efficient use of technology and transparency

Infrastructure

This necessary evaluation component will build on current infrastructure at the State:

- The Office for Oregon Health Policy and Research (OHPR), Research Unit: The OHPR Research & Data Unit has extensive experience developing comprehensive evaluation plans, creating data collection instruments, managing evaluation contracts, and analyzing data from state-wide surveys.
- The Health Indicators Project (HIP): Under the HIP project, leaders in state-wide community access organizations: 1) define a common unit of analysis across the urban and rural areas of the state, termed Primary Care Service Areas (PCSA); 2) identify shared metrics of access to allow communities within PCSAs to compare themselves locally, state-wide, and nationally; and 3) develop a "tool-kit" for local access organizations to tap into existing data resources to answer their community-specific questions in a cost-efficient manner.
- The Oregon Health Research and Evaluation Collaborative (OHREC): OHREC supports evidence-based decision-making by collaborating with health researchers from Oregon's universities, state agencies, advocacy organizations, local community health-care access

initiatives, and a variety of other stakeholders. OHREC is committed to creating a bridge between health-care decision-makers and the research community; thus creating a feedback loop of rapid-cycle research findings that informs policy.

Oregon Health Policy Commission Road Map for Health Care Reform

Sequencing Reforms: A Five-Year Plan

The goal of the Commission's reform work is to develop a five year reform plan that would create a health care system in Oregon in which everyone has access to affordable health care. This section outlines a recommended approach to implementation.

Getting Started in the 2007 Legislative Session

- Pass universal health coverage for children. Ensuring coverage for children is a strong first step in ensuring affordable coverage to all Oregonians.

- Pass legislation outlining the major components of full scale reform, providing guidance to public and private cooperative work throughout 2007-2009.

Years 1 and 2

- Implementation of universal health care for children will occur in Year 1.

- Implementation planning for the Health Insurance Exchange, the publicly-financed coverage expansion, and an employer assessment or fee will take place throughout Year 1 into Year 2.
  - This provides over a year for the Exchange to be created carefully by establishing an independent oversight board, promulgating operating regulations, developing initial benefit packages for individuals and small businesses, and developing affordability standards and the subsidy structure.
  - Also during this time, the state will negotiate the terms of the needed Medicaid waiver amendments to implement the publicly-financed subsidy structure.
  - Implementation of the Exchange, the publicly-funded subsidy structure, and the employer fee will occur by the middle of Year 2.

- Also during the second year, the Office for Oregon Health Policy and Research (OHPR), in partnership with other state agencies, the Oregon Health Research and Evaluation Collaborative (OHREC), policymakers, and national experts, will develop a comprehensive five-year plan for evaluating the reform implementation and initial outcomes.

Years 3, 4, & 5

Individuals have from the passage of the enacting legislation until Year 3 to seek out available coverage. The child coverage expansion, the publicly-funded subsidy structure, and the Health Insurance Exchange are all in place to assist individuals in finding affordable options. Only after the beginning of Year 3 will individuals be subject to penalties if affordable insurance is available per the Exchange affordability standard.

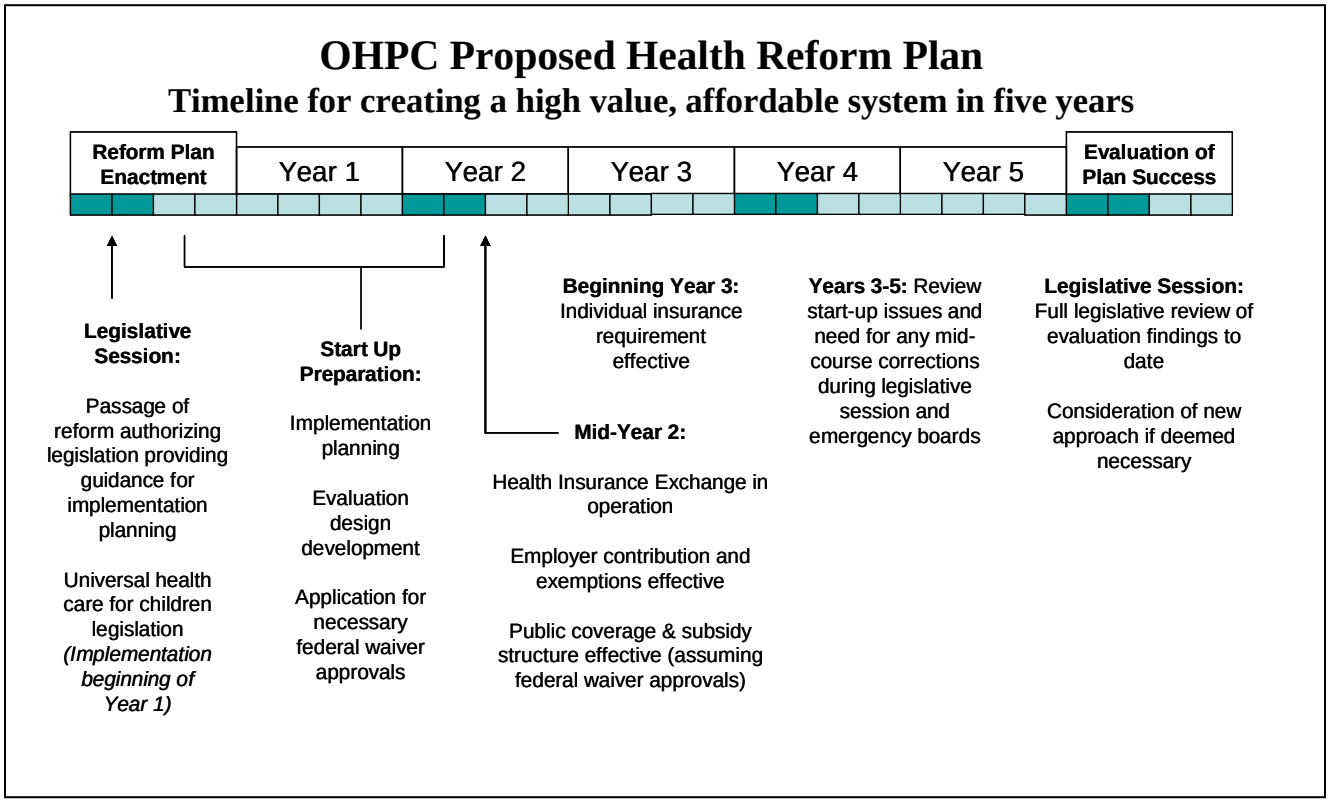
During the legislative session and emergency boards during years 3 through 5, the Governor and Legislature will review implementation progress to date and assess whether any mid-course legislative corrections are required.

Evaluating the Success of Reforms

Upon completion of year 5, the Governor and the Legislature will conduct a public review of progress to date through:

- Preliminary results for review through initial evaluation findings from OHPR and other researchers;
- Feedback from constituents, advocates, providers, insurers, and other stakeholders; and
- Any updated recommendations from the OHPC and other advisory bodies.

Both minor adjustments and full scale direction changes should be on the table for discussion at this point.



Oregon Health Policy Commission
Road Map for Health Care Reform

Priority Policies for Further Development by OHPC

Implementing Senate Bill 329

Senate Bill 329, which outlines a work plan to design comprehensive reform in Oregon, was passed in June 2007. Signed into law by Governor Kulongoski, the bill's goal is the completion of a comprehensive plan by late 2008, followed by reform implementation legislation for consideration in the 2009 session.

The bill includes a detailed timeline for fleshing out a full-scale reform plan in the 2008 legislative session. Under SB 329, the Oregon Health Fund Board, a newly created governmental entity will oversee the development of a comprehensive reform plan and implementation proposal. Five subcommittees will develop recommendations for the Board focused on: 1) financing, 2) delivery system reform, 3) benefit definition (based on Oregon's Prioritized List of Health Services), 4) eligibility and enrollment policies, and 5) federal policy impacts and opportunities. To facilitate the work of the Board and its subcommittees, existing state commissions and committees will form the backbone of the subcommittees.

The Oregon Health Policy Commission is tasked with forming the backbone of the financing subcommittee. As such, the Commission will spend the majority of the remaining time in 2007 researching options for financing the Oregon Health Fund program, and developing recommendations for the Oregon Health Fund Board. Several of the issues the Commission will tackle in this capacity include:

- Developing an implementation plan for a health insurance exchange by February 2008;
- Collecting and pooling employer, employee and individual health care premium contributions; and,
- Developing a model for a Quality Institute to improve how health care information is collected and utilized.

During the public comment period, the Commission received input that reform plans should include consideration of end-of-life care, medical liability, and other topics not covered by this report. The Commission opted to not add these topics in this final report as many of them are listed as topics to consider in implementation of SB 329.

Delivery System Reform

While much of the focus of health care reform is on insurance coverage, real reform must also change our delivery system to ensure that everyone has access to quality and affordable care provided in the most appropriate setting. In our current system, care is often fragmented, with services such as behavioral health and long-term care not well integrated with physical health care. This is in part due to the way services are paid for, and is exacerbated by a system that does not reward provider collaboration.

The OHPC believes that reforming how our health care system pays for services is key to system reform. As discussed under Recommendation #5 in this report, there are numerous entities in the state and nationally focused on reforming how health care is financed and reimbursed. The OHPC will continue to focus on furthering delivery system reform in Oregon. Some key areas of OHPC's work will include:

- Encouraging the most effective care in the most appropriate setting. Our payment incentives should place a particular emphasis on promotion of preventive care, chronic care management, and coordinating care for patients over their lifetime in a continuous way rather than episodically.
- Motivating health care providers to utilize health information technology to improve quality, safety, and transparency by permitting patient information to be available at the point of decision making by both providers and patients. Building the capacity for such infrastructure development in safety net providers and small physician practices should be a focus.
- Ensuring adequate provider capacity to ensure the demand for needed health care is met throughout the state.
- Integrating cost-containment in the system in a way that levels out growth and makes the system more sustainable. Ideally, mechanism for "capturing" savings can be created in order to demonstrate the effect of system reforms.

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The Oregon Health Policy Commission recognizes the valuable contributions of the following individuals:

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Appendix B: Reference on designing the employer contribution to reform in compliance with ERISA

Excerpt From: "Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints." Patricia A. Butler, JD, Dr.P.H. for National Academy for State Health Policy, May 2002.

Do not require employers to offer health coverage to their workers. Such employer mandates would be preempted under the precedent of the case that invalidated Hawaii's law.

Establish a universal coverage program funded in part with employer taxes. The state's legislative objective should be to establish a publicly-financed health coverage program that is funded partially with taxes on all types of employers. Neither the law nor its sponsors should refer to objectives such as assuring that employers cover their workers.

Do not refer to ERISA plans. State laws are easily invalidated if they refer specifically to private-sector employer-sponsored (i.e., ERISA) health plans. The pay or play tax should be imposed on *employers* not on the employer-sponsored plan and the law should not refer to such plans.

Remain neutral regarding whether employers offer health coverage or pay the tax. If the state's objective is to assure universal coverage, it should be neutral with respect to whether an employer pays the tax or covers its workers. The justification for a tax credit is to permit employers to cover workers, but the law and its sponsors should not express a preference for either option.

Impose no conditions on employer coverage to qualify for the tax credit. Despite the state's concerns about adequacy of benefits packages, cost sharing, employer premium contributions, or other employer plan design features, conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems. Like the Massachusetts Health Security Act (designed carefully to avoid these pitfalls), state laws that impose no standards on qualification for the tax credit stand the best chance of overcoming a preemption challenge.

Minimize administrative impacts on ERISA plans. States cannot tax ERISA plans directly; the pay or play tax must be imposed on the employer. While the state law does provide an incentive for the employer (in its capacity as ERISA plan administrator) to assess whether it is more preferable (from cost, management, and employee relations perspectives) to pay the tax or cover workers, this burden alone should not compel ERISA preemption. Designing the pay or play program like other state tax laws (e.g., for remitting unemployment compensation taxes or withholding employee income taxes) can overcome arguments that the state law interferes with interstate employer benefits design and administration, because employers already are subject to varying state tax systems.

6. HEALTH CARE

RECOMMENDATIONS

In order to lower health care costs, improve quality, and expand access to care, the Oregon Business Plan recommends the following:

- Use value-based purchasing strategies by employers and public sector purchasers to improve quality and lower costs. Employers should encourage a culture of wellness and personal responsibility, and design benefit plans to improve health, including coverage of preventive services, management of chronic conditions, protection from catastrophic costs, and incentives for wellness. Employers should also create an effective market for health care: consumer choice of health plans, better consumer information, and appropriate consumer cost sharing. Employers should develop expectations and incentives for health plans and providers to encourage higher quality and use of evidence-based care.
- Encourage investment in health care information infrastructure: electronic medical records, secure exchange of health information among providers, standardized measures of quality, and transparent information on costs and quality.
- Expand Medicaid to reduce the number of uninsured and improve access to care. Use additional state revenue to maximize federal matching funds. Increase payments to providers who serve Medicaid patients to improve access to care. In exchange, providers and health plans should reduce the cost shift by lowering charges to privately-insured employers and individuals.
- Increase access to coverage for individuals and small businesses: require individuals to have health insurance, subsidize low-income workers and individuals to enable them to afford coverage, and create an "insurance exchange" to make it easier for individuals and employees of small businesses to purchase insurance.

Vision

We support actions to give all Oregonians access to quality health care. This can best be accomplished by creating a fair market where everybody is motivated to improve health, ensure quality, and control costs. In such a system, individuals, employers, health plans, and providers have incentives to encourage good health, and consumers make informed choices about health practices and treatment options based on understandable health information and transparent prices and quality.

The Problem

The current health care system in the U.S. and Oregon is not delivering value.

- The U.S. spends a much higher share of its GDP on health care than other developed countries.
- Health insurance premiums have been increasing at an unsustainable rate.
- The quality of care in the U.S. is inconsistent

ACCOMPLISHMENTS TO DATE

√ Published a white paper summarizing the problems and root causes of high health care costs and inconsistent quality

√ Developed the business case for a pilot project to enhance the exchange of health information among providers and locations of care.

√ Supported efforts to develop websites to provide comparative information on hospital prices and quality.

√ Collaborated with initiative to develop standardized quality measures for outpatient care.

√ Developed a partnership with the Oregon Coalition of Health Care Purchasers (OCHCP) to educate employers and encourage them to use more effective purchasing strategies for health benefits.

and often below the standards of other developed countries.

- Our health care system leaves many people – nearly one-sixth of the population -- without health insurance coverage.

Why is this important for businesses and all Oregonians? The Oregon business community has identified health care as one of the most serious cost problems it faces. The high cost of health benefits:

- Makes it more expensive for Oregon businesses to compete in a global market
- Reduces funds for business investment
- Dampens economic recovery and job growth
- Reduces funds available for cash compensation to employees

The Oregon business community has identified health care as one of the most serious cost problems it faces.

In addition, the high cost of publicly-financed health care crowds out needed public investment in education and transportation.

Lack of consistently high quality care also is a serious concern. Employee productivity is reduced, and – much more importantly – lives are being lost. The lack of access to coverage for many Oregonians is unacceptable in our society, and the costs for caring for the uninsured are shifted to those who have insurance, putting an additional cost burden on businesses and individuals.

Health Care Task Force

In response to these concerns, the OBC Health Care Task Force was commissioned in the spring of 2004.

The task force had four primary objectives:

- Understand the health care problem in Oregon and the impact on businesses and the community
- Educate businesses and the community regarding the problem and its impact
- Develop a long-term vision and principles to address these problems
- Create a proposal for comprehensive redesign of the health care system.

Challenges

The health care system is badly broken and needs to be redesigned. The problems of cost, quality and access are driven by three closely related factors:

- Fundamental cost drivers
- Lack of effective market forces
- The vicious cycle of costs and access to care

[Note: These factors are described in more detail in the OBC's white paper, "A New Vision for Health Care," December 2004.]

Fundamental Cost Drivers

- *Aging.* The percentage of the population over 65 is increasing steadily.

- *Chronic conditions.* It is estimated that five conditions (heart disease, mental disorders, pulmonary disorders, cancer, and trauma) have driven a large portion of overall cost increases during the past 15 years.
- *Technology.* New advancements in diagnostic and treatment technologies are providing new alternatives, many of which extend life or improve health, but at increased cost.
- *Unhealthy lifestyles.* Poor health choices and the lack of personal accountability for health -- exacerbated by limitations on public health initiatives – contribute to higher costs. For example, the scope and impact of the obesity epidemic are well-documented.

Lack of Effective Market Forces

There are four important levers that have the potential to drive improvements in the value – cost, quality and service – delivered by our health care system:

- Consumer choice
- Price sensitivity
- Information to support informed consumer choice
- Healthy competition between providers

How is this working in the current U.S. health care system?

*Choice***.** The majority of employed Americans do not have a choice of health plans offered by their employers.

Price sensitivity. Most consumers are shielded from the real costs of health care. In this situation, consumers lack financial incentives to manage their demand for health care services, and they lack strong economic incentives to shop for efficient health care providers. (Although new benefit plans with considerably higher cost sharing – often known as "high deductible health plans" – have been introduced in recent years, they are still a relatively small share of the market.) Furthermore, many employers pay the full premium or a high percentage of the full premium, regardless of the cost. As a result, there is little incentive for employees to choose the most efficient health plan. In addition, many physicians are unaware of the costs of providing services and are not in a position to assist patients in making cost-effective choices.

Information. It is difficult to obtain useful and reliable data to compare the cost and quality of health plans and providers. Consumers are often not in a position to make informed decisions about the diagnosis and treatment of diseases, and must rely on providers to tell them what medication or treatment is needed. Publicly available information on health care costs and quality is gradually reaching consumers, but it is currently inadequate to support informed decision-making by most of them.

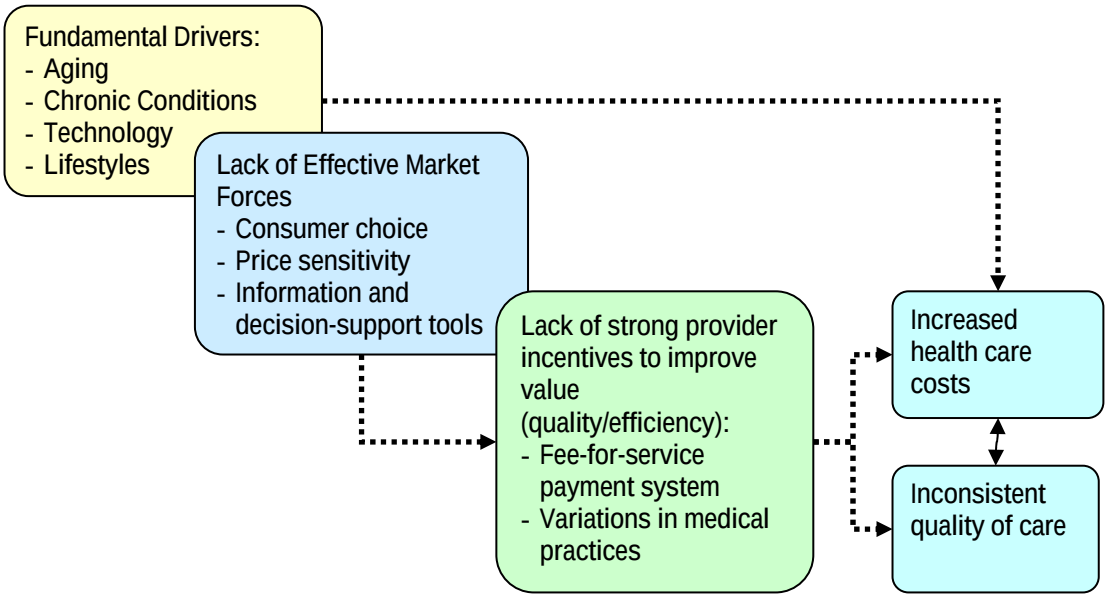
Healthy Competition. Given this situation, there is little incentive for health plans or providers to differentiate themselves and compete on cost or quality. Exacerbating this problem is the fact that most providers – especially physicians – are paid on a fee-for-service basis, i.e., a fee for each service delivered. This compounds the effects of the fundamental drivers of demand for medical care. For a physician to be successful financially, s/he is driven to provide a greater number of services. While this may or may

not result in improved health outcomes, it can cause more services to be delivered than are necessary. In some cases, over-treatment can also cause poor medical outcomes. (See Figure 1 for a graphic summary of these factors.)

The problems of lack of consumer choice, useful information and healthy competition are

Figure 1.

THE ROOT CAUSES OF HEALTH CARE COST INCREASES



especially acute for employees of small businesses and non-employed individuals. Health plans will usually provide coverage to small groups only on an exclusive basis, thereby eliminating the opportunity for consumers to make choices. The lack of choice also reduces "portability" by making it more difficult for employees to stay with a particular health plan when they move from one job to another. Small businesses seldom have the time or expertise to shop effectively for health insurance, thereby weakening their purchasing power. From the health plans' perspective, small group and individual coverage incurs higher administrative and selling costs, and the claims costs for this segment are subject to higher risk variation. As a result, the rates charged to small groups and individuals are higher and less stable year-to-year, although rate regulations dampen these problems to some degree.

Other Factors

- The medical care delivery system is very fragmented. Most physicians are self-employed in solo practices, and only 25 percent are in practices of eight or more. This is an obstacle to creating more efficient care delivery processes, investing in electronic health information systems, and coordinating care more effectively for patients. It also has contributed to the slow and inconsistent adoption of "evidence-based guidelines" for medical practice, leading to both under- and over-treatment of

common conditions. It has also delayed the implementation of initiatives to reduce serious medical errors.

- The U.S. health care system has very complicated administrative processes. As a result, administrative costs are high – 7 percent of total health care expenditures according to government statistics. Some researchers estimate that total system administrative costs – including costs hidden in hospital and physician costs – are much higher (31 percent). Part of this is due to the market fragmentation among providers, health plans, and purchasers. As a result, the system has a high level of duplication and a lack of standardization.
- The lack of a well-developed infrastructure or standards for health care information systems has also been a major obstacle. Health care information exists in a multitude of places in varying formats, some paper, some electronic. This has created inefficiency because information flow between consumers, providers, employers and health plans is not timely. This adds expense due to redundancy and re-work. Furthermore, the delays in the availability of health information can lead to compromised safety and quality.

There is a complex but powerful relationship between rising costs and deteriorating access to care.

The Vicious Cycle of Costs and Access

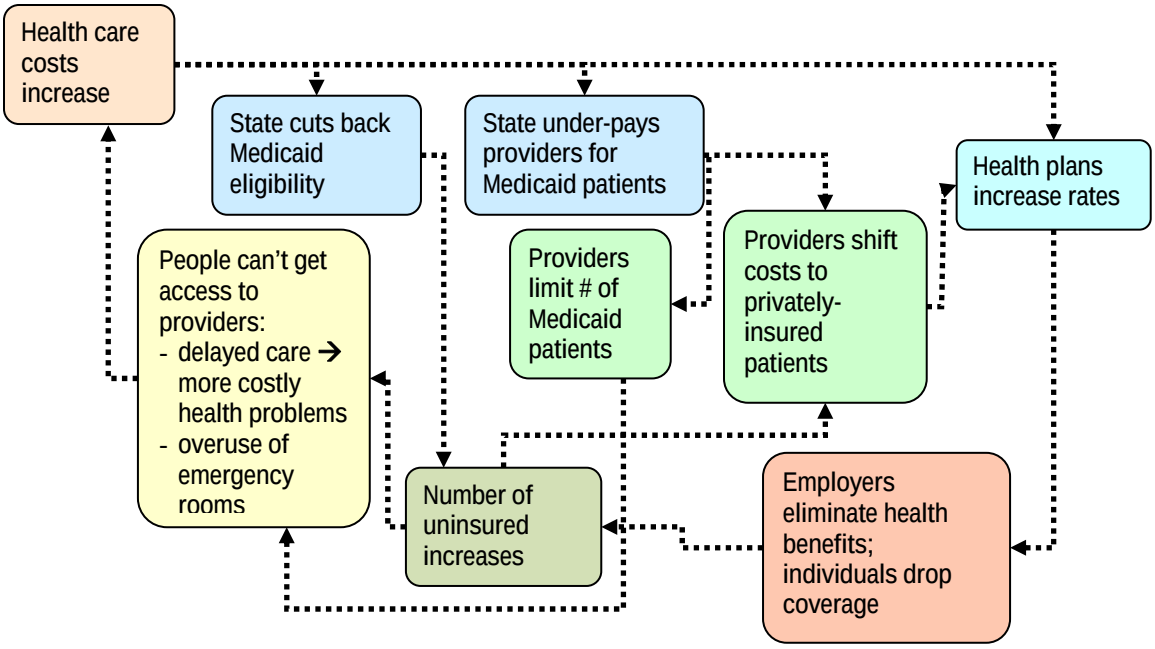
There is a complex but powerful relationship between rising costs and deteriorating access to care.

- The most basic dynamic starts with cost increases that drive higher health insurance rates. As a result, many employers are reducing coverage, especially for dependents, or are dropping employee health benefits altogether. Similarly, increasing health care costs have forced the state to reduce the number of people in the Medicaid program (Oregon Health Plan). These actions by employers and state government have increased the number of uninsured, for whom it is much more difficult to get access to care.
- The increase in the number of uninsured and the resulting access problems results in delayed treatment and inappropriate use of hospital emergency departments for non-emergency care. This further increases costs, creating a vicious cycle by increasing insurance rates and putting additional pressure on employers and the state to reduce coverage.
- The increasing number of uninsured non-paying patients in hospital emergency departments also forces hospitals to charge higher rates for insured patients. This cost shift results in higher insurance rates, creating another vicious cycle by forcing employers to reduce coverage, thereby increasing the number of uninsured.
- Higher costs have also forced the state and federal governments to under-pay for care provided to Medicare and Medicaid patients. This has led many providers to set caps on the number of Medicare/Medicaid patients they will see, thereby exacerbating the access problem. This also contributes to the cost shift, as providers increase charges for insured patients to offset the low payments for Medicare and Medicaid patients.

As a result, employers and individuals with health insurance carry an additional burden. In addition to higher insurance rates caused by the fundamental cost drivers described earlier, the rates are increased further due to the cost shift. The magnitude of the cost shift is estimated to be 10 to 15 percent in addition to basic health insurance rates. (See Figure 2 for a graphic summary of these factors.)

Figure 2

THE VICIOUS CYCLE OF HEALTH CARE COSTS AND ACCESS



The linkage between costs and access is further complicated by the complex health care financing system in the United States. There are three primary ways in which health benefits are financed:

- *The employer-based system, which covers 52 percent of the total population in Oregon.* Employees and their dependents receive benefits that are largely paid by employers. The benefits are determined by the employer or through collective bargaining. The value of the health benefits is exempt from personal income taxes. (Individuals who purchase health insurance directly account for an additional 6 percent of the population.)
- *Medicaid, which covers 12 percent of Oregonians.* Low-income people in certain eligibility categories receive benefits. The eligibility rules and benefits are set by the federal government, with some flexibility at the state level.
- *Medicare, which covers 13 percent of Oregonians.* Elderly and disabled people are eligible to receive benefits. The benefits are established and administered by the federal government.

Each of these major categories has different funding mechanisms, eligibility requirements, benefit designs and administrative jurisdiction. As a result, many people fall between the cracks of these categories. For example, many part-time or seasonal employees, dependents, and employees of small businesses do not have benefits. Many

low-income people are not eligible for Medicaid because they do not fit into one of the aid categories, but they are unable to afford health coverage. By limiting eligibility to the very poorest, we effectively discourage work.

Agenda for 2007 and Beyond

The OBC Health Care Task Force has developed a set of recommendations to address the problems with the current health care system. The proposals are built upon an understanding of the root causes and a set of core principles:

Principles

1. There are three essential issues to address: cost, quality and access. Many reform proposals focus only on access. We believe this is insufficient. Any proposal that does not address the system changes needed to reduce costs will be unaffordable. We are committed to finding solutions that are economically sustainable.

2. The health care system is badly broken and needs fundamental change. Fixing the problems of high costs, inconsistent quality, and poor access will take sustained and focused effort over many years. Ultimately, the system of delivering health care services requires major restructuring. Some improvements can be driven by changes in health care financing and purchasing, but those changes alone will not be sufficient to improve the cost and quality of health care services.

3. This is a systemic problem that requires collaborative problem-solving. It's easy to look for and blame villains, but that won't fix the problem. All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution. The business leaders working on this initiative are committed to collaborating with key stakeholders and policy-makers to achieve reform.

All of the key stakeholders – consumers, employers, providers, health plans and government – are part of the systemic problem, so we all must step up to be part of the solution.

4. All stakeholders must accept their responsibilities for improving the system. Consumers have a responsibility to keep themselves healthy and be well-informed purchasers. Providers have a responsibility to help keep their patients healthy and to offer evidence-based, cost-effective care to all who need it – including publicly-subsidized as well as privately-insured patients. Employers have a responsibility to offer health benefits to their employees and dependents, if they can afford it, and help keep their employees healthy and productive. Health plans have a responsibility to offer coverage to all who need it and work with providers to reduce costs and improve health outcomes. The government has a responsibility to ensure access to coverage and care to all who need it and use value-based purchasing strategies to encourage efficiency and quality.

5. We believe that a system that is built on the private health care delivery system and uses market forces is most likely to achieve the goals of cost control and quality. While there is an appropriate role for government as a facilitator, regulator and purchaser/sponsor for low income and elderly persons, we believe that the private

delivery system – with the right incentives for providers – is the best way to improve quality and cost effectiveness**.** Consumer engagement and personal accountability are critical. Consumers must have real choices, an appropriate level of price sensitivity, and access to information and decision support tools.

6. We need practical solutions that can be implemented. Although it is necessary to have a long-term vision for a redesigned health care system, it isn't fruitful to imagine an ideal future system that is impossible to achieve. We must find pragmatic approaches that build a bridge from the existing health care system to a future system that delivers value and provides access to evidence-based care. We recognize that investments in basic infrastructure, e.g., development and publication of standardized quality data, electronic health records, and the exchange of health information among providers, etc., are needed to support a new health care system.

7. Business leadership is needed to drive improvements in the health care system. As the primary purchaser of health benefits, employers – on behalf of their employees –have a major stake in ensuring that the money spent is producing value. Building on the employer-based system makes sense; it already covers the majority of Oregonians reasonably well. In addition, this will help to ensure that employers continue to have a stake in keeping employees healthy and productive. Building on the employer-based system also allows employers to customize their health benefit programs to meet their employees' needs.

A Responsible Plan for Sustainable Reform

The following are the key elements of a comprehensive redesign of the health care system in Oregon. We have focused on state-level initiatives at this time, recognizing that even greater improvements could be made with reform at the national level. The first two elements focus on actions by purchasers – working with health plans and providers – to improve the quality and lower the costs of the health care system. The remaining four elements address the vicious cycle of costs and access to care.

Improve Quality and Lower Costs Through Purchaser Action

Use value-based purchasing by employers and public sector purchasers. Private and public sector employers can play a major role in driving improved quality and lower costs. There are several general principles and approaches that purchasers should use:

Private and public sector employers can play a major role in driving improved quality and lower costs.

- Encourage a culture of wellness and personal responsibility in the workplace.
- Offer benefits that are designed to improve health; coverage should include:
  - Preventive services
  - Management of chronic conditions
  - Protection from catastrophic costs
  - Incentives for wellness
- Create an effective market for health care:
  - Offer employees a choice of health plans and providers

  - Engage employees in their health care decision making by using a defined contribution approach to fund employees' health benefits and requiring cost sharing at the time of service – while avoiding financial barriers to preventive services or chronic care management Provide employees with decision support tools, including understandable cost and quality data, to support their ability to make informed choices of health plans, providers, and alternative treatments and services.

- Contract more effectively with health plans, using standardized RFI tools and setting expectations for health plans and providers to improve transparency, cost-effectiveness, quality of care, and use of evidence-based care.

In addition, public sector programs such as Medicaid must operate as efficiently as possible to ensure that beneficiaries and taxpayers are getting the best value for the money. The Medicaid program should be allowed to use the same tools (e.g., use of a preferred drug list, integration of mental and physical health programs) that businesses use in managing their health benefit programs. With these tools, any expansion of the Medicaid program would be more cost-effective.

Invest in information infrastructure development. Private and public sector purchasers should work with health plans and providers to stimulate the development of health care information infrastructure, including:

- Electronic Health Records should be adopted by all health care providers.
- Providers should have access to necessary patient health information through secure data exchange mechanisms in order to provide continuity of care.
- Data transparency is needed to allow purchasers and consumers to be more informed buyers.
- Standardized and easily understood measures of quality are needed to enable purchasers and consumers to compare the performance of providers.

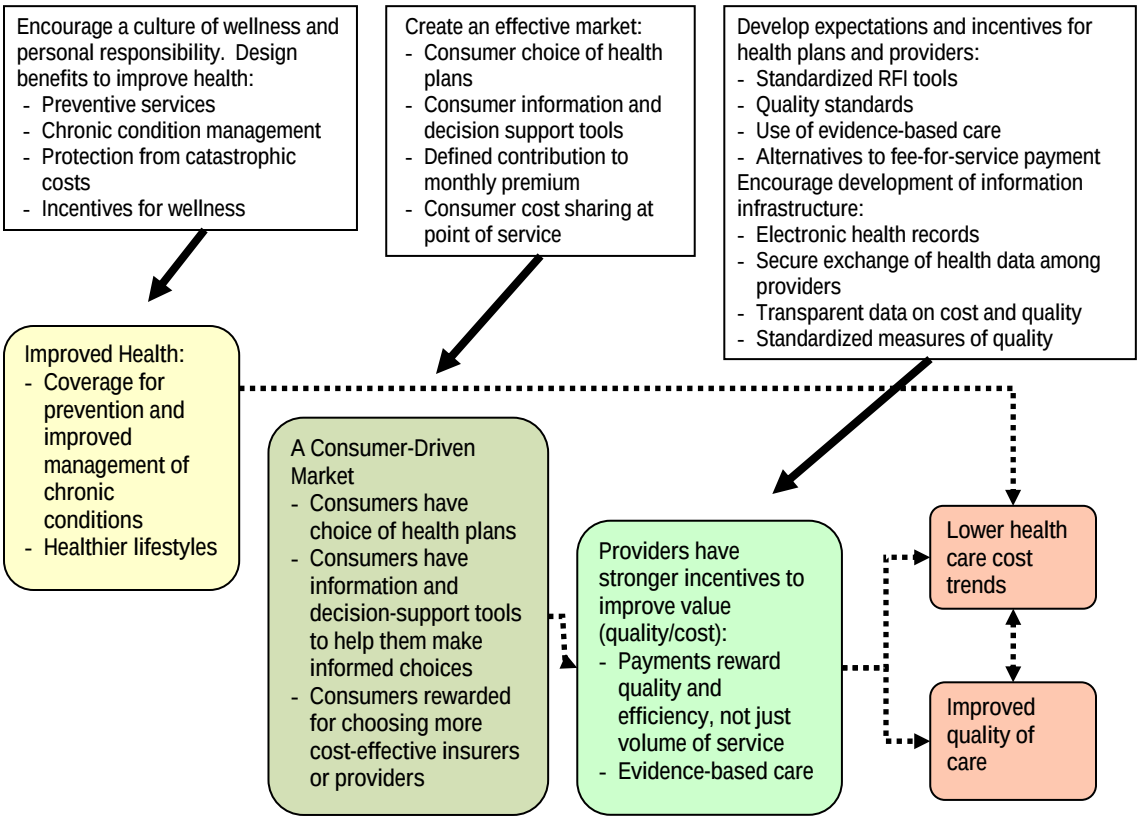
(See figure 3 for a graphic summary.)

Break the Vicious Cycle of Costs and Access.

Reduce the number of uninsured by expanding Medicaid. Use additional state revenue to maximize Federal matching funds that are currently available to the state. Increasing state funding by $700 million would generate over $1 billion in additional federal funds annually.

Improve access to care by increasing payments to providers who serve Medicaid patients. Use a portion of the additional Medicaid funds to reduce the gap between provider payments for publicly- and privately-insured services.

Figure 3
USING VALUE-BASED PURCHASING TO IMPROVE VALUE: QUALITY/COST

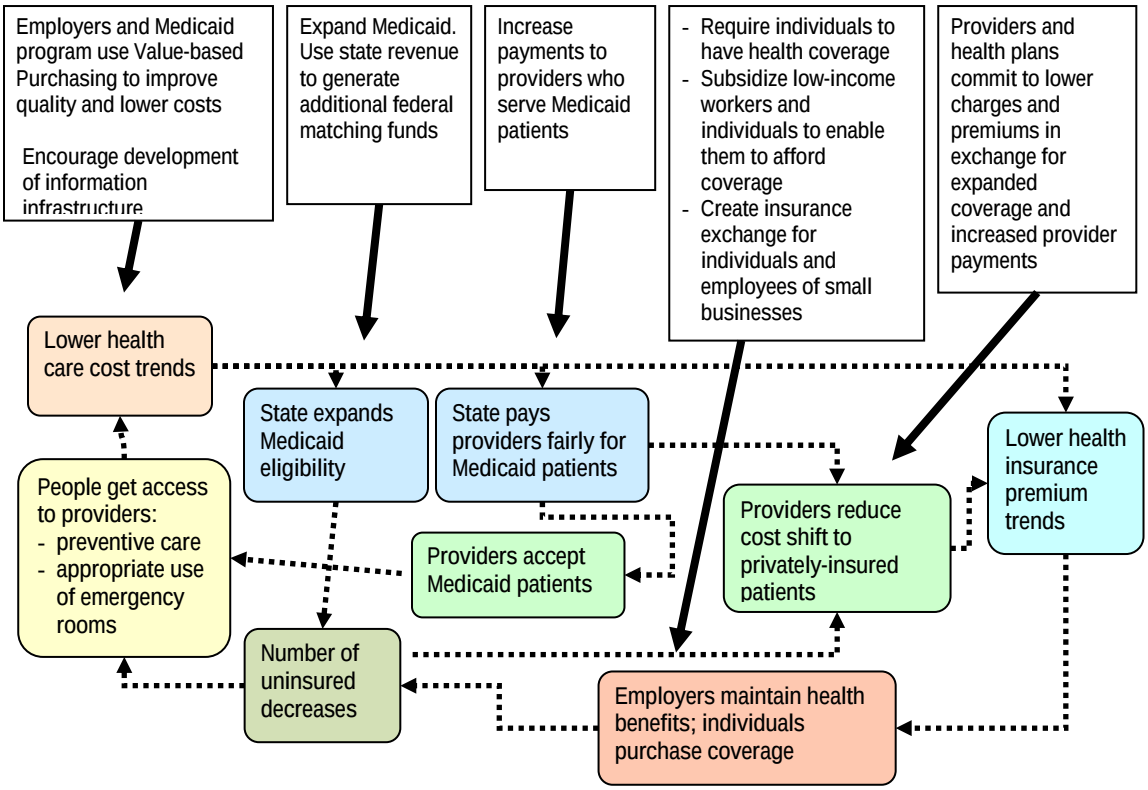


Increase access to coverage for individuals and small businesses. This is needed to address the special problems that individuals and small businesses face in obtaining coverage. For many, coverage is unaffordable. Some individuals who can afford coverage, however, choose to forego insurance. When they become seriously sick or injured, they rely on hospitals which are required to serve everyone regardless of coverage. The health care costs for these "free riders" are borne by those who have insurance, via the cost shift described above. Three specific steps are needed:

- Require individuals to have health insurance.
- Subsidize low-income workers and individuals to enable them to afford coverage.
- Create an "insurance exchange" for individuals and employees of small businesses

Reduce the cost shift to employers and individuals. In return for expanded coverage and increased provider payments, health plans and providers should reduce the cost shift by lowering charges to privately-insured employers and individuals. (See Figure 4 for a graphic summary of these recommendations.)

Figure 4
BREAKING THE VICIOUS CYCLE



Short-term Initiatives (2007-08)

Focus on Improving Quality and Reducing Costs

1. Use Value-based Purchasing by employers to improve quality and lower costs.
2. Support legislation that allows the Oregon Health Plan to implement purchasing strategies used by private employers, e.g., use of a preferred drug list, integration of mental and physical health programs
3. Continue efforts to improve health care information infrastructure: electronic health records, secure exchange of health data among providers, transparent information on costs and quality, and standardized quality measures
4. Support Medicare initiatives for improved transparency, quality improvement and pay for performance

Improve Access and Reduce the Cost Shift

5. Support the cigarette tax to fund comprehensive and affordable health coverage for children – the Healthy Kids Plan
6. Support the use of state revenue to gain federal matching funds and expand the Oregon Health Plan
7. Support efforts to increase provider payments for Oregon Health Plan patients and reduce the cost shift to privately-insured patients

8. Oppose efforts by Medicare to further reduce payment rates to providers, or other steps that would exacerbate the cost shift to privately-insured patients
9. Create a forum and collaborate with other organizations to develop a plan for comprehensive redesign of the health care system to provide all Oregonians with access to high quality and affordable care.

Measuring our Progress

We will measure our progress against the following goals [specific targets to be developed]:

Health and Wellness of Employees. Employers incorporate the value of employee health and wellness in the culture of their organizations and their decision making processes.

Outcomes:

- Employers use health risk assessments to develop wellness and prevention programs with incentives to engage employees and to take personal responsibility
- Employees and their families do not have financial barriers to needed preventive and chronic care
- Employers offer evidence-based disease management programs
- Overall health status of employees and dependents improves.

Access. Provide access to care for all Oregonians.

Outcomes:

- Reduce the number of uninsured in Oregon..
- Increase the number of providers willing to care for Medicaid and Medicare patients..

Create appropriate incentives to drive efficiency in health care. Structure the health care market to offer informed consumer choice and encourage healthy competition among providers.

Outcomes:

- All consumers have a choice of health plans
- Information regarding cost, quality and service is easily accessible for consumers and group purchasers to make informed choices between health plans and providers.
- Consumers have the appropriate degree of cost sharing, without creating barriers to needed care
- Providers have the appropriate financial incentives to provide high quality and cost effective services.

Costs. Create a health care system that is affordable and economically sustainable.

Outcomes:

- Reduce the annual increase in overall health care costs,
- Reduce the annual increase in health insurance premiums.

Quality. Improve the quality of health care services.

Outcomes:

- Patient health information is available to providers across systems.

- Employees with chronic conditions are well managed.
- Employers measure health care quality through standard metrics.
- Evidence-based guidelines are used by clinicians.

If we are able to achieve these outcomes, Oregon businesses will have a competitive advantage, thereby increasing economic growth and jobs. The people of Oregon will be healthier and lead more productive and rewarding lives. And Oregon can strengthen its reputation as an innovative leader in social and economic policies.

Health Care Initiative Leaders

Peggy Fowler, President & CEO, Portland General Electric
Mark B. Ganz, President & CEO, The Regence Group.

Background Resources

OBC white paper, "A New Vision for Health Care," December 2004.

The Office for Oregon Health Policy and Research (OHPR)

The Office for Oregon Health Policy and Research (OHPR) is responsible for the development and analysis of health policy in Oregon and serves as the policymaking body for the Oregon Health Plan. The Office provides analysis, technical, and policy support to assist the Governor and the Legislature in setting health policy. It carries out specific tasks assigned by the Legislature and the Governor, provides reports and conducts analyses relating to health care costs, utilization, quality, and access.

The Office for Oregon Health Policy and Research also carries out its responsibilities by providing staff support to statutorily established advisory bodies responsible for health care policy recommendations including: the Oregon Health Policy Commission, the Health Services Commission, the Health Resources Commission, the Advisory Committee on Physician Credentialing, the Medicaid Advisory Committee, and the Safety Net Advisory Council. It also coordinates the work of the Oregon Health Research and Evaluation Collaborative and the Oregon Prescription Drug Program.

OHPR Programs

The *Oregon Health Policy Commission (HPC),* enacted in the 72nd Legislative session, is responsible for health policy and planning for the state. The Commission identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Legislature and OHPR.

The *Health Services Commission (HSC)* prioritizes health services and benefit categories for the Oregon Health Plan. The Health Services Commission created and maintains the Prioritized List of Healthcare Services, which ranks health services by efficacy and cost for Oregon's Medicaid program, the Oregon Health Plan.

The *Health Resources Commission (HRC),* established in 1991, conducts medical technology assessments to assure that Oregonians are not incurring health expenses for redundant or ineffective services. The Commission encourages the rational and appropriate allocation and use of medical technology in Oregon by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. Currently, the Commission is focusing on the Practitioner-managed Prescription Drug Plan, working with OHSU's Evidence-based Practice Center to review the medical literature to determine the effectiveness of certain groups of prescription drugs.

Advisory Committee on Physician Credentialing Information (ACPCI) develops minimum uniform credentialing information of physicians for Oregon's hospitals and health plans.

The *Medicaid Advisory Committee (MAC)* advises the Oregon Health Policy Commission, OHPR and the Department of Human Services on the operation of Oregon's Medicaid program, the Oregon Health Plan.

The *Oregon Health Research and Evaluation Collaborative (OHREC)* is a statewide organization that includes health care researchers from Oregon's distinguished universities, state and county agencies, representatives of managed care organizations, hospital systems, mental health and substance abuse advocates and a variety of other stakeholders. OHREC produces and presents research focused on the impacts of policy changes to the Oregon Health Plan population.

The *Oregon Prescription Drug Program (OPDP)* is a prescription drug purchasing pool authorized by the 2003 Oregon Legislature to help increase access to prescription drugs by the uninsured and lower costs for state and city governments to help them stay within budgeted goals. The OPDP meets these goals by pooling prescription drug purchasing power, using evidence-based research to develop a preferred drug list of lowest cost drugs, negotiating competitive discounts with pharmacies and bringing transparent pharmacy benefit management services to groups. The OPDP unites Oregon's prescription drug purchasers to leverage the best prices on the most effective medicines.

OREGON HEALTH FUND BOARD
DELIVERY SYSTEM COMMITTEE
Draft By-Laws
Adopted by OHFB _____

ARTICLE I
The Committee and its Members

- The Delivery System Committee ("Committee") is created by the Oregon Health Fund Board ("Board"). The Committee's function is to study, review, discuss, take public comment on and develop policy options and recommendations to the Board, consistent with the Committee's scope of work as determined by the Board.

- The Executive Director of the Board and staff employed or arranged for by the Executive Director shall serve as staff to the Committee. The Office for Oregon Health Policy and Research (OHPR) and other state agencies will support the work of the Committee in a manner mutually agreed upon by the Executive Director and the respective entity(ies).

- The Members of the Committee will be appointed by, and serve at the pleasure of, the Board. The Committee shall cease to exist upon a majority vote of the Board to disband the Committee.

- Members of the Committee are not entitled to compensation for services or reimbursement of expenses for serving on the Committee.

ARTICLE II
Committee Officers and Duties

- The Committee shall select a Chair and up to two Vice Chairs from among its Members. The Officers will serve for 24-months from the date of their election or until the Board disbands the Committee, whichever occurs first.

- Duties of the Chair are:
    - Serve as a non-voting Member of the Board. The Chair will sit with the Board and participate in all Board discussions, but shall not be permitted to make, second or vote on motions, resolutions or other formal actions of the Board.
    - Preside at all meetings of the Committee.

- Coordinate meeting agendas after consultation with Committee staff.
- Review all draft Committee meeting minutes prior to the meeting at which they are to be approved.
- Be advised of all presentations or appearances of the Executive Director or staff before Legislative or Executive committees or agencies that relate to the work of the Committee.
- The Chair may designate, in the absence of the Vice-Chair or when expedient to Committee business, other Committee Members to perform duties related to Committee business such as, but not limited to, attending other agency or public meetings, meetings of the Board, training programs, and approval and review of documents that require action of the Chair.

- Duties of the Vice Chair are:
  - Perform all of the Chair's duties in his/her absence or inability to perform;
  - Accompany the Chair to meetings of the Board at which final recommendations of the Committee are presented; and
  - Perform any other duties assigned by the Chair.

ARTICLE IV
Committee Meetings

- The Committee shall meet at the call of the Chair in consultation with the Committee Members and staff.

- The Committee shall conduct all business meetings in public and in conformity with Oregon Public Meetings Laws. The Committee will provide opportunity for public comment at every meeting in accordance with policies and procedures adopted by the Board.

- The preliminary agenda will be available from the Committee staff and posted on the Board website [*healthfundboard.oregon.gov*] at least two working days prior to the meeting. The final agenda will be established by Committee members at the beginning of each Committee meeting.

- A majority of Committee Members shall constitute a quorum for the transaction of business.

- All actions of the Committee shall be expressed by motion or resolution. Official action by the Committee requires the approval of a majority of a quorum of Members.

- On motions, resolutions, or other matters, a voice vote may be used. At the discretion of the Chair, or upon the request of a Committee Member, a roll call vote may be conducted. Proxy votes are not permitted.

- If a Committee Member is unable to attend a meeting in person, the Member may participate by conference telephone or internet conferencing provided that the absent Committee Member can be identified when speaking, all participants can hear each other and members of the public attending the meeting can hear any Member of the Committee who speaks during the meeting. A Committee Member participating by such electronic means shall be considered in constituting a quorum.

- Committee Members shall inform the Chair or Committee staff with as much notice as possible if unable to attend a scheduled Committee meeting. Committee staff preparing the minutes shall record the attendance of Committee Members at the meeting for the minutes.

- The Committee will conduct its business through discussion, consensus building and informal meeting procedures. The Chair may, from time to time, establish procedural processes to assure the orderly, timely and fair conduct of business.

ARTICLE V

Amendments to the By-Laws and Rules of Construction

- These By-laws may be amended upon the affirmative vote of five (5) Members of the Board.