**Office for Oregon Health Policy and Research**

# HRSA State Planning Grant

*Pilot Planning Grant Final Report*

**September 2006**

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*September 30th, 2006*

***Note:***
This is the final report of Oregon's Pilot Planning Grant, but an addendum describing final activities of the Grant through Oregon' no-cost extension will be submitted in early 2007

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## Oregon's Pilot Planning Grant – *Executive Summary*

Even while facing serious fiscal challenges, Oregon remains committed to the goals outlined in its original HRSA State Planning Grant application. This is the final report of Oregon's Pilot Planning Project (but an addendum describing final activities of the Grant through Oregon' no-cost extension will be submitted in early 2007)

The specific aims for this project relate to Oregon's original HRSA State Planning Grant's three goals:

1. ***To increase health insurance through the expansion of both public and private financing.***
2. ***To increase the proportion of eligible people who apply and receive Medicaid coverage.***
3. ***To improve the capacity and capability of Oregon's healthcare delivery system, including safety net clinics, to provide care to uninsured populations.***

Specific aims of the Oregon Pilot Project Planning grant proposal were

- *Activities 1 and 2: Benefit Redesign with Children's Enrollment and Outreach:* To carefully assess a sustainable approach to covering more children and non-categorical adults in the Oregon Health Plan (OHP- Oregon's Medicaid program) and the premium subsidy program, Family Health Assistance Insurance Program (FHIAP). These activities were a critical piece of the preparation for final statewide consensus on policy options as the state prepares for an upcoming Legislative session and our Medicaid waiver renewal. A majority of these activities aimed to maximize enrollment of children eligible through the private–public partnership of FHIAP or Medicaid/OHP. Economic and actuarial analysis of options provided detailed information for the State's decision makers. These activities aimed to institutionalize the "lessons learned" from past years' HRSA-funded research and fold them into Oregon's overall strategies to maximize enrollment in both public and private coverage, applying initially to children, and later to adult populations.
- *Activities 3 And 4: Developing Better Measures of Access to Health Coverage and Engaging Communities:* Our original aim was to provide planning and technical assistance to communities working toward 100% Access. "Local initiative" modeling can provide valuable information on how such communities can provide for broader community-level expansion by reforming their delivery systems and maximizing finances. Building on past HRSA-sponsored data collection efforts, the Health Indicator Project aimed to develop measurable healthcare access benchmarks that could be used across the state as well as potentially within local communities as new coverage options are implemented. These activities also aimed to review and improve Oregon's Population Survey (OPS) to ensure its reliability and validity as a tool for monitoring health insurance status in the state, working closely with Oregon's Office of Multicultural Health to better reach racially and ethnically diverse populations. All these activities allow better evaluation of policy options successes and provide stakeholders with information for future evidence-based decision-making.
- *Activity 5, Arkansas Multi-State Integrated Database:* Continued participation in this project.

The lead agency for this project has been the Office for Oregon Health Policy and Research (OHPR). 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 also staffs the Oregon Health Policy Commission, the Health Services Commission and the

Medicaid Advisory Committee. Key partners in our proposed Pilot Project Planning activities include the Department of Human Services and its Offices of Medical Assistance Programs (OMAP) and Multicultural Health (OMH), Children, Adults and Families (CAF); the Family Health Insurance Assistance Program (FHIAP), which is housed in Oregon's Office for Private Health Partnerships (OPHP)and the Oregon Health Policy Commission.

These pilot planning grants have allowed Oregon to move forward to cover 117,000 uninsured children including an estimated 68,000 uninsured children below 200% FPL through the Governor Kulongoski's Health Kids Plan. We are also positioned to make progress for the 138,000 uninsured adult Oregonians under 100% of federal poverty level (FPL) and building towards even broader reform efforts. If enacted, these policy options can restore much of the impact of the past years' cuts and build sustainable programs that can withstand future economic fluctuations. Specifically, the implementation status of the project activities are:

**Healthy Kids Plan – to provide access to coverage for <u>all</u> of Oregon's uninsured kids**

- Poised to go into the Governor's Proposed Budget and the upcoming 2007 Legislative Session with broad bi-partisan support
- Further implementation planning in progress, so if get Legislative approval could proceed with CMS approval and implement by January 2008

**Work on revising OHP Standard benefits so can afford to cover more uninsured adults under 100% of FPL**

- Key Stakeholder group convened to review the newly re-organized Prioritized List of Health Services to develop a potential redesigned benefit package focused on preventive and chronic diseases predominately so can afford to cover more uninsured adults under 100% of FPL in OHP Standard

**Work towards broader health reform to increase access to health coverage**

- Oregon Health Policy Commission is developing its strategic health reform approach, focusing on adopting aspects of the Massachusetts Reform on top of existing programs of the Oregon Health Plan, with a report due to the Governor by January 2007. Also working closely with other health reform efforts in the state including former Governor Kitzhaber's Archimedes Movement and efforts by the Senate Commission on Healthcare Access and Affordability. Anticipate much discussion in 2007 Legislature and possible legislation.

**Development of better measures of access to health coverage**

- *Health Indicator Project Benchmarks*
    - Wrapping up the final benchmark list and working with local communities to gain input and positioning the work as a key component of any coverage expansion options to assist in evaluation and success of potential initiatives. Final consensus and strategic plan will be completed by the end of our no-cost extension in February 2007

- *Improved methodology for the Oregon Population Survey (OPS) and measures of health coverage*
    - Work completed and the 2006 OPS is in the field, awaiting assessment of the improvements

These Pilot Planning Grant activities have been an integral component of allowing Oregon to pursue coverage expansion options. Oregon's recommendations to Federal Government are:

- **The HRSA State Planning Grant program has provided invaluable resources to states to allow them to plan and design coverage options for the uninsured that otherwise would not have been possible and the Pilot Planning Grant program should be continued.**
- **The Pilot Planning Grant application process was labor intensive, as were the original Planning grant and should be shortened. It is challenging for states to devote the magnitude of staff time required to gather all the information required, and the information is not shared with others beyond those reviewing the grants so the information is usually not usable for others. However, the reporting requirements of the Pilot Planning Grant were vastly more straightforward and a better means of reporting gains from the Pilot Planning grant activities.**
- **Access to expertise such as SHADAC and others involved with the HRSA State Planning Grant program have been key to any success we have had by being a resource for complex issues faced by multiple states, providing analytical technical support, not generally found within state governments. The Federal Government could support further technical assistance opportunities to allow ongoing work with such key expertise consultants.**
- **Partnership with the RWJF State Coverage Initiative (SCI)Program and regular interaction with other HRSA State Planning Grantees has provided valuable networking that allows an avenue to exchange new option ideas, share pitfalls and lessons learned, and allow informed evidence-based decision making by our individual state policymakers. The Federal Government could support ongoing avenues of interaction in collaboration with the SCI Program.**
- **Evidence-based decision making by state and national policymakers is vital, so funding of policy option evaluations is a key piece not well supported at the state or federal level, and private foundation dollars are limited. The Federal Government should consider increased support of health services research and evaluation as states try new approaches to covering the uninsured. Increased funding for translating research back to state and national policymakers should be included as an essential element of any funding for health services research.**

## Background and Previous HRSA SPG Accomplishments:

**Earlier Efforts to Reduce the Number of Uninsured Residents**

This section outlines the states extensive efforts of the last 15 years to develop innovative ways to improve access to health insurance for Oregonians.

**The Oregon Health Plan:** In 1987, Oregon initiated its health care reform efforts, collectively referred to as the Oregon Health Plan (OHP), in an attempt to reduce the number of uninsured Oregonians, strengthen its economy, and improve the health status of its citizens. At that time, 18% of Oregon's 2.85 million residents were uninsured, and the unemployment rate was 5.7%. In addition, the cost of health care was consuming an ever-growing portion of public and private sector budgets. The goal of the OHP was universal access to an adequate level of high quality health care at an affordable cost. The OHP has provided access to quality health care services for more than one million uninsured people and helped to decrease uninsurance in the state to as low as 10% in 1998, although it has since increased to 17% in 2004.

The major components of the original Oregon Health Plan were:

- Medicaid reform
- Insurance for small business
- High risk medical insurance pool
- Employer mandate

*Medicaid Reform:* The Oregon Health Plan (OHP) has been an innovative example of Medicaid reform, including a basic benefit package that expanded public coverage to the federal poverty level (FPL)[1] for families and adults, a managed care delivery system, and prioritized and integrated mental, physical and dental health care services. The OHP sought to lower costs by reducing cost shifting through expanding coverage, emphasizing managed care, preventive care, early intervention and primary care, and prioritizing the coverage of effective care over less effective treatments. Prior to March 2003, the OHP covered:

- Low-income adults beyond the mandatory groups up to 100% of the Federal Poverty Level (FPL)
- Children (Under 19 years of age) up to 170% of FPL through Medicaid or SCHIP
- Pregnant women up to 170% of FPL

*Insurance for Small Business:* As part of the Oregon Health Plan, the Insurance Pool Governing Board (IPGB) was created to encourage private-sector group health insurance market growth with a limited expenditure of public-sector funds. [2] In 1997, Oregon's Legislature created the Family Health Insurance Assistance Program (FHIAP), which offers premium subsidies to assist Oregonians with incomes up to 185% FPL to purchase private coverage.

*High-Risk Medical Insurance Pool***:** The 1987 Legislature created the Oregon Medical Insurance Pool (OMIP) to provide affordable health insurance to individuals denied coverage in the individual insurance market due to pre-existing medical conditions. Over the last ten years,

*1 For 2004 Federal Poverty Guidelines, see Appendix B.*

2 IPGB designed a basic, no-frills benefit package that was offered by small group insurance companies at a set price for both small employers and self-employed, exempt from some insurance mandates, and if the employer had not offered group health insurance benefits for two years. At its peak, over 20,000 employers purchased these IPGB-certified plans, enrolling more than 60,000 employees and their dependents. Later insurance reforms enacted by the Oregon Legislature during the 1990's decreased the need for these specialized plans, and there was a migration to plans in the regular market.

OMIP has provided coverage to almost 30,000 Oregonians otherwise unable to purchase coverage and has been a factor in FHIAP's success. Enrollment has risen to more than 7,000 individuals. OMIP is funded by the purchase of coverage by individuals, employers, and an assessment of insurers based on an insurer's total market share.

*Employer Mandate*: The employer mandate was never implemented, but would have required all employers to offer group health insurance or pay into a statewide insurance pool through a payroll tax. Implementation was dependent on Congressional exemption to the federal Employee Retirement Income Security Act (ERISA), which the state was unable to obtain.

**Changes to OHP in 2003:** Facing the highest unemployment rate in the nation and an unprecedented budget deficit, Oregon turned to cost sharing and benefit reduction in the Oregon Health Plan in 2003. Building on its 1115 waiver and using the flexibility provided by the Health Insurance Flexibility and Accountability (HIFA) initiative, Oregon developed changes to the program in a waiver referred to as OHP2. These efforts separated the Medicaid program into two benefit packages—OHP Plus and OHP Standard. OHP2 waiver changes also resulted in including the State's premium subsidy program, the Family Health Insurance Assistance Program (FHIAP) under Medicaid so it could receive federal match for what had been previously funded with only state dollars.

The OHP Plus benefit package and cost sharing structure is similar to the original OHP and serves low-income seniors, people with disabilities, families meeting the eligibility criteria for Temporary Aid to Needy Families (TANF) and children and pregnant women. The OHP Standard benefit package, designed for Oregon's expansion population (who are adults, 19 to 64 years of age up to 100 percent of the FPL), implemented in February 2003 is leaner in benefits and implements significant co-pays. Premiums were increased for those enrolled in OHP Standard and administrative rules were tightened, including a six-month lockout for nonpayment of premiums. These changes were derived from objectives developed through extensive community input and advisory groups. The objectives were to:

- Generate revenue to provide flexibility in designing the OHP Standard benefit package that would otherwise have a very limited coverage level.
- Instill in clients the value of health care and ongoing coverage by structuring the program to include cost- sharing for accessing certain services and for maintaining eligibility.
- Make OHP Standard similar to commercial plans as a transitional step to private health insurance.

The original policy goal of OHP2 was to expand coverage to 185% FPL for children, pregnant women and adults through savings accrued by implementing the leaner OHP Standard benefit package, cost sharing and premiums. However, as the severity of Oregon's budget shortfall intensified, the reductions in coverage were implemented, but much of the expansion was not realized. In addition, the Oregon Legislature in March 2003 eliminated outpatient mental health and chemical dependency for the OHP Standard population. These benefits were reinstated in August 2004. Prescription drug coverage for OHP Standard was also eliminated but reinstated after two weeks following intense public pressure.

**Chart A: OHP 2 Waiver Changes, February 2003**

| | Waiver Provisions | Number Affected |
|---|---|---|
| **Reductions Implemented** | OHP Standard benefit package for Oregon's expansion population (adults, 19 to 64 up to 100% FPL). The changes were:<br>• Increased cost sharing and premiums<br>• Reduced benefit package<br>• Ability to cap enrollment<br>• No waivers of premiums for zero income<br>• Six-month lock out for non-payment of premiums | 99,894 in OHP Standard as of end of month February 2003<br>As of September 2004, OHP Standard enrollment was 52,008 |
| **Expansions Implemented** | Children (up to 19) and pregnant women increased from 170% FPL to 185% FPL<br>Family Health Insurance Assistance Program (FHIAP) eligibility increased from 170% to 185% | *An additional 2,557 children and 438 pregnant women as of September 2004*<br>An additional 454 enrollees between 170% and 185% as of January 2005 |
| **Expansions Not Implemented** | Parents, from 100% to 185% FPL<br>Childless adults (19 to 64) from 100% to 185% FPL<br>FHIAP to 200% FPL<br>Children to 200% FPL | NA |

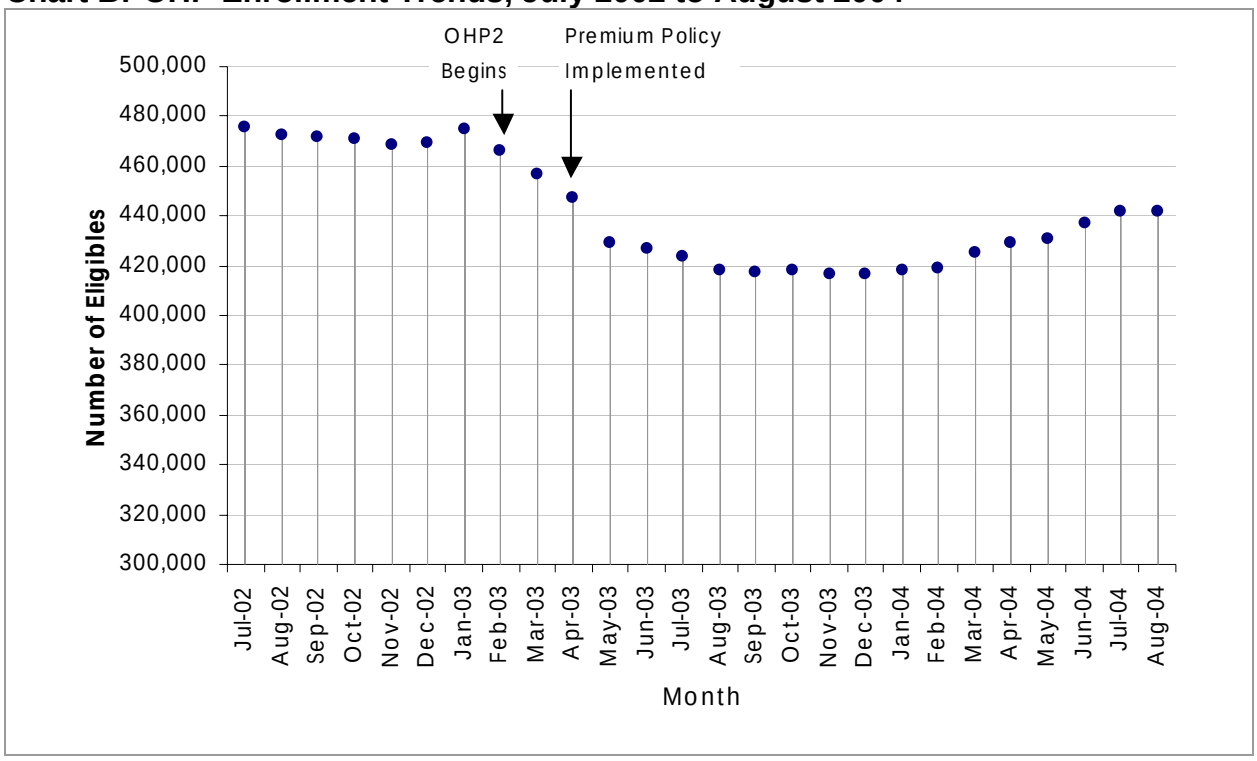
**Changes to OHP in 2004:**

*Elimination of Co-payments for OHP Standard*: In early 2003, the Oregon Law Center legally challenged the OHP Standard premium and co-payment policies authorized by the Centers for Medicare and Medicaid Services (CMS). The litigation (Spry v. Thompson) found that OHP Standard co-payments violated federal law; they were eliminated effective June 19, 2004, according to the court order. While the court decision did not affect OHP premium policies, OHP Standard co-payments are no longer a consideration as a cost sharing mechanism for future OHP Standard program changes.

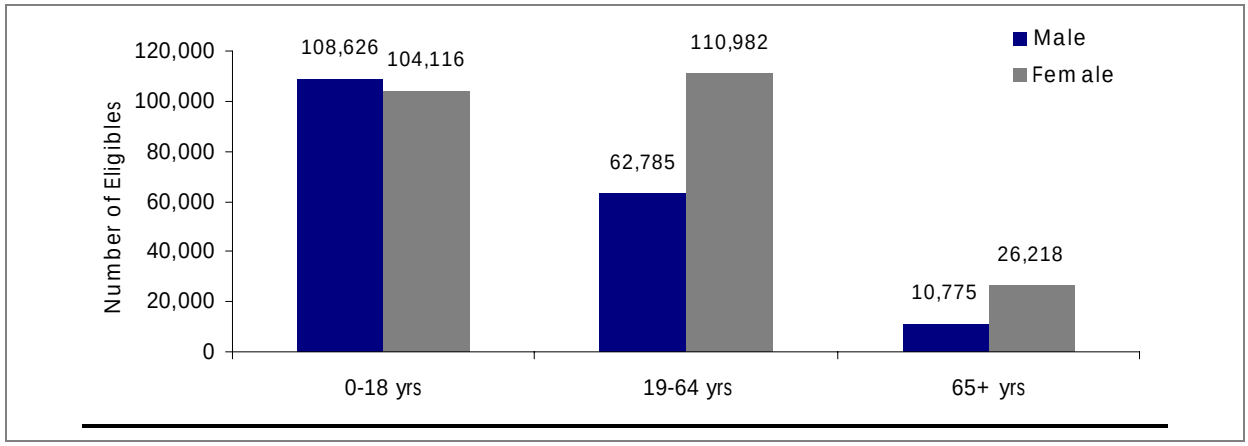
*OHP Standard Status as of Summer, 2006:* The OHP Standard program:

- Operates entirely without General Fund resources, using provider taxes from the hospitals and managed care organizations, and premium payments from enrollees.
- Serves a reduced number of clients based on available provider tax revenue, premium payments, and federal matching funds.
- The program is currently closed to new enrollment.
- Has a redefined benefit package effective August 2004, which re-instated outpatient mental health and substance abuse treatments and very limited dental coverage.

## Chart B: OHP Enrollment Trends, July 2002 to August 2004




## Chart C: OHP Medicaid and CHIP Enrollees, September 2004




Data Source: Oregon Medical Assistance Program (OMAP)

*Family Health Insurance Assistance Program (FHIAP)*: A key tenet of the Oregon Health Plan was to build on public – private partnerships, reflected in Oregon's original HRSA SPG grant first goal. The state's health insurance premium subsidy program is an example of such a partnership. The Family Health Insurance Assistance Program (FHIAP) provides over 8,500 Oregonians with subsidies for their private health insurance premiums.

The program was created in 1997 with state-only dollars to address the needs of families who do not qualify for Medicaid or Medicare, but can't afford private coverage. Following the design work done under Oregon's original HRSA SPG, FHIAP was incorporated into the OHP2 waiver in 2002. With the availability of federal matching dollars, the program serves allows more Oregonians to participate in the private health insurance market.

*Benefits:* Members enroll in their employer's group insurance plan if one is available; otherwise they enroll in an individual plan. The member is responsible for co-payments, co-insurance, and all deductibles. There is a basic benchmark benefit for subsidized employer-sponsored coverage that is comparable to coverage commonly found in the small employer or group health insurance market. This benchmark was developed as a tool to determine which health insurance plans offered by employers would be eligible for subsidy under the auspices of FHIAP.

**Chart D: FHIAP Enrollment by Subsidy Level, January 2005**

| Subsidy Level | % FPL | Individual | Group | Total |
|---|---|---|---|---|
| **95%** | *<=125%* | *3,036* | *1,891* | *4,927* |
| **90%** | *126% - 149%* | *1,023* | *1,056* | *2,079* |
| **70%** | *150% - 169%* | *408* | *648* | *1,056* |
| **50%** | *170% - 185%* | *136* | *318* | *454* |
| **Total** | *Na* | *4,603* | *3,913* | *8,516* |

Source: FHIAP Snapshot of Program Activity, 01/24/2005www.ipgb.state.or.us/fhiap/index.html

OHP Premium Sponsorship: As a result of the dramatic decline to the OHP Standard caseload, a significant community response has been the development of OHP premium sponsorship by various organizations around the state. OHP Standard enrollees are required to pay a percentage of the premium share based on their income, and to make timely premium payments or face disqualification from the program. If disqualified, they are not eligible to re–enroll for six months.

As part of its HRSA SPG activities, Oregon examined Washington's Basic Health Plan and that model of financial sponsorship. Components of the Washington model were implemented in May 2004, keeping more than 2,000 OHP Standard enrollees from disqualification. The community collaboration goal is to sponsor enough enrollees so that none are disqualified due to failure to pay premiums. Currently, the sponsoring organizations pay for all past due premiums for clients under 10% of the federal poverty level who are at risk of being disqualified. A workgroup of advocates and stakeholders continues to work closely with OMAP to develop sustainable processes for the premium sponsorship program.

*Additional Notable Program Changes:* Oregon's Medically Needy program was also eliminated due to budget cuts in February 2003, and efforts were soon initiated to reinstitute coverage. State dollars are now directed to a small subset of the formally Medically Needy for organ transplant and HIV patients. Efforts to initiate a Medicaid Pharmacy Plus waiver program were not successful. However, as of March 1, 2005, the state started enrolling people in the **Oregon Prescription Drug Program (OPDP)**. OPDP consolidates drug purchasing across state and local agencies and provides discounts for those 55-64 years of age without drug coverage. The state partnered with the American Association of Retired Persons (AARP) in its marketing with an initial application mailing to 1,500 individuals who had been waiting for the program's rollout. Major pharmacies in the state have agreed to participate, and several local governments are exploring their ability to participate with their next benefit renewal cycle.

**Impact of most recent policy reforms:** OHPR worked with our state Medicaid agency, OMAP, to form the Oregon Health Research and Evaluation Collaborative (OHREC), an innovative partnership of the policy and academic health services research communities, to study the impact of waiver changes using funding from Oregon's Robert Wood Johnson Foundation State Coverage Initiatives (SCI) grant. Some of the key findings included:

**Enrollment Impacts:**

- OHP Standard enrollment fell 50% from approximately 102,000 clients in 2002 to approximately 51,000 in late 2003
- Low-income single adults have been most susceptible to the premium policy changes in OHP Standard, with the zero income group most affected (58% decline in enrollment)
- New enrollments among the zero income group dropped sharply and have not returned to pre-implementation levels
- Premium cost was the most common reported reason for loss of OHP Standard coverage
- Most (72%) who lost coverage remained uninsured at the time the study was undertaken

*Unmet Need:* Research found that clients who lost OHP Standard coverage had higher unmet health care needs:

- 60% reported unmet need for medical care; 80% for mental health care
- Clients with chronic illnesses were more likely to report unmet needs

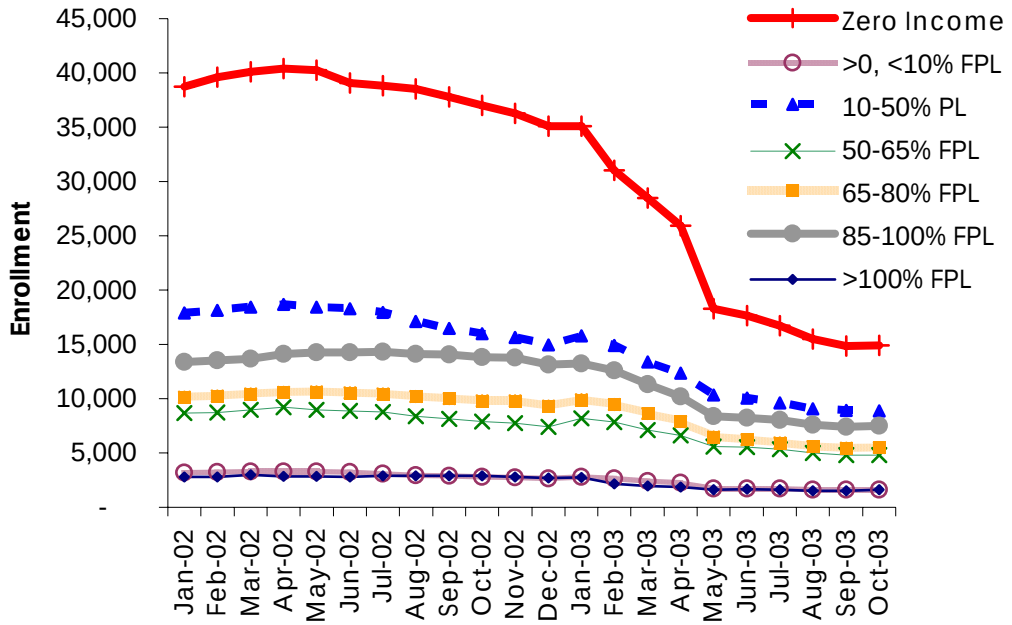
*Utilization Impacts:* Research found that clients who lost OHP Standard coverage were:

- Nearly three times more likely to have no usual source of care
- More likely to skip filling a prescription due to cost (57% vs. 48%)[3]
- 4 to 5 times more likely to go to the emergency department for care

The following chart shows the differential impact of OHP2 premium policy changes by income level:

*3 At the time the survey was undertaken, OHP Standard required co-payments for prescription drugs ranging from $2 to $15 per prescription.*

## Chart E: Impact of Premiums and Administrative Lockout on OHP Enrollment




Source: McConnell KJ, Wallace N, "The Effect of Premiums and Administrative Lockout on OHP Enrollment", Presentation to Oregon Health Research and Evaluation Collaborative (OHREC), January 22, 2004. Available at http://www.oregon.gov/DAS/OHPPR/RSCH/ohrec.html

As is shown in Chart E, the lowest-income individuals (especially the zero income group) have been most affected by the premium amount and administrative changes to OHP Standard. The changes (removal of the homeless and zero income waiver criteria and implementation of the six-month disqualification) in premium policy were at least as important as the premium amount changes. The Kaiser Family Foundation Health Policy Forum invited testimony from OHPR about these premium impacts to provide information to legislative staff and advocates as MediCal redesign was being crafted. Results from OHREC research were also presented to the Connecticut Legislature as they considered cost sharing changes in their Medicaid program. Most recently, the Colorado SCHIP requested this data to inform their HIFA waiver design process.

Despite a sharp economic downturn, Oregon remains committed to its original HRSA State Planning Grant goals of increasing access to health insurance coverage for more Oregonians through efforts to 1) increase expansion of public and private programs, 2) increase enrollment of those already eligible, and 3) improve capacity and demand in Oregon communities' delivery systems.

***Earlier Grant Activities:*** Early grant activities were focused on gaining an understanding of what viable expansion options had already been studied, nationally or otherwise. Policy analysts reviewed single-payer proposals, tiered systems, primary care models and methods of incremental change. In order to understand the willingness of Oregonians to change the current system, we contracted with a local university to examine attitudes toward healthcare. The survey found that 65% of Oregonians rated health care as a top issue, while only 4% rated it at the bottom. Most felt fundamental change was necessary (56%), and some felt that the entire system

needed to be rebuilt (18%). A majority of respondents expressed a willingness to pay more, either in higher health insurance premiums or higher taxes, in order to extend access to medical care to more Oregonians.[4]

In order to understand what policy options Oregonians would support, we contracted with researchers to conduct focus groups of low-income uninsured individuals, small employers and health care providers or administrators. These results indicated that uninsured Oregonians don't expect coverage to be free. They desire affordable coverage that is sensitive to their shifting financial situation and means. The study also revealed the crucial role of the health care safety net in providing affordable, timely, and culturally sensitive health care to both the uninsured and publicly insured populations.

Small employers acknowledged the importance of offering employee health coverage, and indicated a willingness to do so if the state offered tax benefits. Health care providers and administrators supported the idea of a prescription drug formulary to reduce costs incurred under the Oregon Health Plan, legislation that was subsequently passed by the Oregon Legislature.

With HRSA funds, we undertook a survey of enrollees and those waiting to enroll in Family Health Insurance Assistance Program (FHIAP), which was then state–only funded. At the time, FHIAP was limited to 5,000 enrollees and had more than 17,000 people on their reservation list. Many were eligible for other public assistance. The survey explored the nature of the choice to enroll in FHIAP rather than Medicaid or SCHIP and asked a sample from the reservation list why they chose to wait rather than apply for Medicaid. The overwhelming response was that individuals and families prefer something that looks like private insurance rather than Medicaid and, most significantly, are willing contribute to the cost of that coverage.

Subsequent questions arose about how those with very low income (those below 100% FPL) would access a program that required any additional cost–sharing. This led to another project, collaboration with the State of Washington to analyze member survey data of Basic Health enrollees at or below the federal poverty level. Basic Health enrollees pay a portion of their premium and are responsible for co-pays and coinsurance. The data affirmed what was found in the FHIAP survey; even those with very little income were willing to pay something toward their premium, co-pay and co-insurance. This data was used by the Legislature and the OHP2 Waiver Application Steering Committee to help frame decisions about public and private financing of care and the potential impacts of cost-sharing.

OHPR also undertook an analysis of the Oregon Medical Insurance Pool (OMIP), the state's high-risk pool. OMIP is funded through purchase of coverage by individuals, employers and assessment of insurers based on an insurer's total market share. Insurers have expressed particular concerns that public subsidies provided to FHIAP enrollees in OMIP increase their assessment. Recent trends, increasing enrollment in the high-risk pool and the doubling of rejection rates in the individual market indicate that this is an important experience to learn from.

During the summer of 2002, OHPR staff interviewed providers in six Oregon communities considered to be 'small Medicaid markets.' We examined existing agreements between OHP carriers and safety net providers to serve the uninsured, gaps in care for the uninsured; financing,

[4] *A summary of original research conducted under the auspices of the HRSA State Planning Grant can be found at: http://www.ohppr.state.or.us/.*

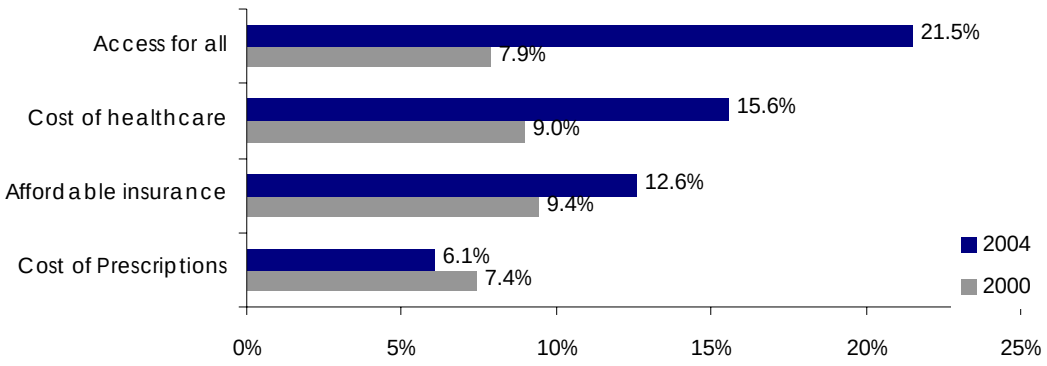
cost sharing and continuity of care concerns; and local OHP outreach and enrollment efforts. This report has provided invaluable linkages and strategies for continued improvement of Oregon's safety net.

Oregon has a long history of involving the public in the policy process, especially in the health care arena. Oregon Health Decisions (OHD) [5], an independent citizen organization dedicated to bringing the public into the process of shaping health policy has conducted a statewide survey periodically since 1996 to assess Oregonian's basic values around health care policy issues. The HRSA SPG grant team partnered with OHD to focus on how to delineate which benefits Oregonians would support as the economy improves and additional funds might become available. Several legislative committees have been working to design a 'road map' to prioritize how populations will be returned to the OHP. What was missing was input from Oregonians, which has historically been an integral component of OHP decisions.

The 2004 Health Values Survey, a telephone survey conducted with 531 Oregonians yielded these key findings:

- Oregonians report that access for all and costs of health care and insurance were the top three health care problems that need to be solved in Oregon.
- An estimated 21.5% indicated that access for all was the most important issue, followed by concerns about the cost of health care and affordable insurance.
- The degree of consensus about these issues in 2004 is important to note; in 2000, cost of health care, affordable insurance, and cost of prescriptions were ranked as the top three concerns.

**Chart F: Most Important Health Care Issues, 2000 & 2004**




[5] *Oregon Health Decisions (OHD) originally started in 1982 as an outreach effort by the Oregon Health Council. It evolved into an independent organization whose aim is to bring the general public into the process of shaping health policy. OHD has developed values information from the public for living will legislation, the development of practice guidelines, and the tasks of technology assessment and distribution. The organization played a pivotal role in organizing community meetings for the Oregon Health Services Commission in its work of creating a prioritized list of health services, a central feature of the Oregon Health Plan.*

Further findings of the Health Values Survey included:

- The majority of the public believes that all Oregonians should be guaranteed *basic* and *routine* health care services. Eighty-five percent agreed with this concept, but fewer agreed that *any* needed care should be guaranteed for all.
- Support for guaranteed access has declined slightly from 2004, but Oregonians increasingly support basing decisions regarding guaranteed services on cost and effectiveness of the treatment.
- When choosing between services to include in coverage for all Oregonians, the public cited preventive and primary care services as the overwhelming top priority.
- The public indicated that infants and small children should be prioritized first when allocating health care dollars for all Oregonians.
- Oregonians strongly support the policy that, when funds are limited for the Oregon Health Plan, policy-makers should reduce services but keep as many people as possible in the program.

Strategies supported by survey respondents to help the uninsured obtain coverage included the following:

- Use of public programs for those who are employed and unemployed and use of tax dollars to make health insurance affordable
- Discounted/sliding scale payment for public programs and purchased insurance
- Required employer contribution to their worker's premiums

Concurrent with the Health Values Survey, OHPR conducted additional public input community meetings for the Oregon Health Policy Commission (HPC) during the summer and fall of 2004. The HPC used the all of these results to shape short-range recommendations to the 2005 Oregon Legislature and will continue to incorporate the public input as they develop more long-range recommendations for the state's strategic health plan.

Over the past four years, the HRSA SPG grant team has reviewed numerous national and local proposals for universal coverage. Oregon used supplemental funds to partner with two local organizations; the Metropolitan Alliance for Common Good (MACG) and the Foundation for Medical Excellence (TFME) to develop an approach to Health Dialogues focused on universal coverage options**.** [6] The MACG sponsored a meeting in 2004 on education, tax reform and health and attracted close to 5,000 attendees. MACG wanted to partner with OHPR because of our extensive experience in gathering public opinion on major health care issues through open public meetings. MACG has proposed employing Health Dialogues[7], with the intent of reaching beyond the Portland Metropolitan area to rural communities in order to broaden participation in

[6] *The Metropolitan Alliance for Common Good (MACG), a collaborative group consisting of representatives from labor, faith–based, and other advocacy organizations a public, non–profit foundation created in November, 1984 to promote medical excellence through education and research*

[7] *Health Dialogues will use the process of Viewpoint Learning, which conducted health dialogues all across Canada at the request of the Canadian Parliament.*

discussion and decision–making processes. The steering committee with participation from key healthcare stakeholders continues discussions about how to fund a statewide Health Dialogues effort.

One of Governor Kulongoski's key agendas for the state has been the Children's Charter announced in 2004, which included his intent to expand health insurance coverage for children as a component. Other states have implemented strategies that include branding their children's SCHIP product, targeted enrollment, elimination of the uninsurance requirement for kids, eliminating the assets test or signature page requirements, use of online applications and either 12 month eligibility or passive re-enrollment. With the Governor's commitment to expand coverage to more children, even with Oregon's depressed economy, there is much Oregon has learned from the experience of these other states as it has undertaken the design of Oregon's Healthy Kids Plan under this Pilot Planning Grant.

With our past year's supplemental grant, OHPR, in collaboration with an investigator at Oregon Health & Science University, we designed and completed a Children's Access Survey, building on the Centers for Disease Control and Prevention's (CDC) National Survey of Children with Special Health Care Needs (2001) and the National Survey of Children's Health (2003). This survey effort has provided specific regional information essential to assessing children's barriers to access to healthcare in such a way that community-level interventions can be designed. Information developed from this survey, coupled with what can be learned from other states' efforts was used by the Medicaid Advisory Committee to develop policy options to address the large number of uninsured children in the state as they made initial recommendations to the Governor for the design of Healthy Kids Plan under this year's Pilot Planning Activities. Furthermore, this survey information will assist the Oregon Medical Assistance Program (OMAP), the Medicaid agency and Oregon's Office for Private Health Partnerships as they plan the implementation of targeted outreach efforts toward children who are eligible for Medicaid or SCHIP, but not currently enrolled.

Pas year's HRSA funding was also directed towards establishing the OHP Premium Sponsorship collaborative, a statewide pool of donated funds that was used to pay past-due premiums for clients who are in danger of disqualification from the OHP at the lowest premium level (0 >10% FPL; $6 premiums) following some of the benefit design changes in the Oregon Health Plan due to budget cuts. The Premium Sponsorship Workgroup provided an avenue to begin discussions in Oregon around approaches individual communities can use to increase health insurance coverage, adding local funding to the mix of commercial and public financing.

Due to the efforts of the Oregon Health Research and Evaluation Collaborative in documenting the impact of past benefit policy changes on the OHP combined with the efforts of key healthcare advocates, the Legislature adopted a change in the premium policy so that those below 10% of FPL no longer pay premiums during the 2005 Legislative session. CMS recently granted permission to change the policy in April and this policy change went into effect June 1, 2006. Along with the elimination of premiums for those under 10% FPL group, other changes included a grace period of up to six months for premium payment and a requirement that overdue premiums are paid before clients are eligible again.

There has been significant and focused effort in the state to maintain the infrastructure and framework for expansion even in the face of serious budget shortfalls. Data and information gathered through previous years' HRSA State Planning Grants proved critical to holding onto

Oregon's 1115 and HIFA expansions. Information gained from HRSA-funded surveys of the Family Health Insurance Assistance Program's (FHIAP) enrollees and reservation list proved invaluable in demonstrating to the Legislature that access to insurance through private insurance premium subsidies was critical.

Oregon had started the important process of bringing often disparate, fragmented data together to inform policy. In 2004, Oregon participated in the National Governors' Association's (NGA) technical assistance collaboration with the Agency for Healthcare Research and Quality (AHRQ), *Enhancing the Safety Net Through Data-Driven Policy*. Oregon's Health Care Safety Net Policy Team, a group of key stakeholders, convened as part of the NGA/AHRQ effort in order to develop data-driven policy options. These policy options were specific to sustaining and strengthening the health care safety net providers and those they serve. One of these recommendations led Oregon to begin the work of developing performance indicators and benchmarks, which when completed, will allow us to monitor both the impact of policy changes and the health and stability of our delivery systems, including the safety net. This dataset will include information currently collected from multiple sources, such as the Oregon Primary Care Association (OPCA), Oregon Community Health Information Network (OCHIN), Oregon Hospital Discharge Data and surveys fielded by OHPR.

This past year's work was focused on refining the set of indicators started as part of the NGA project through our Health Indicator Project (see below under Pilot Planning Activities). These indicators measure capacity, access, and outcomes of Oregon's delivery systems with an aim to establish benchmarks that will allow the state to design and implement data-driven health delivery system policy. A combined dataset for the purposes of performance monitoring will help to inform the state as we implement new coverage strategies.

## Summary of Pilot Grant Activities

### Activity 1 and 2: Benefit Redesign and Children's Enrollment and Outreach:

### *Chosen Policy Option: Oregon's Healthy Kids Plan*

As noted in our past activities, Governor Kulongoski has been keenly focused on expanded access to health insurance to children. His Children's Charter announced in 2004 included expanded outreach in a few pilot counties to enroll those children already eligible and an increase in the assets test limit. Governor Kulongoski announced his full Kids Initiative in February 2006, which has been the focus of the majority of Oregon's Pilot Planning Grant activities.

Prior to February, an initial framework to meet the Governor's goal of covering all children was developed through October and November 2005, with the HRSA team working with leaders in the Executive Branch, including the Department. of Human Services, Oregon Medical Assistance Program (Medicaid), the Insurance Division and the Governor's Office. A Design Team has been formed representing the Medicaid and Family Health Insurance Assistance Program agencies (Now called the Office of Private Health Partnerships or OPHP) working with the HRSA team at OHPR to further develop the framework of the children's initiative. Oregon's 1115 and HIFA Waivers are up for renewal, but due to timing of those deadlines and Oregon's biennial Legislature, those waivers that will be renewed in the interim. The full Legislature is required to approve necessary waiver amendments to implement any coverage expansions. The HRSA- supported activities are a vital aspect of the planning of those amendments.

Following direction from the Governor, the state's Medicaid Advisory Committee (MAC)[8] started in February to develop recommendations for the Healthy Kids plan. The MAC worked through the information the HRSA team and the agencies could provide on issues of access and barriers to care, including the results of the HRSA-funded Children's Access Survey. We collected information from other states and Oregon's Covering Kids grant results for their review in terms of program design, branding, outreach tactics and other approaches to reach the uninsured families. Public meetings were held around the state to discuss issues of affordability and benefit design (see below for more details) and the MAC also worked with our actuarial consultants to determine potential benefit structure and costs. This work continued through the late winter/early spring and concluded with a series of recommendations (See Appendix 3), and in time for agencies' budget as well as legislative concepts development for the next Legislative session.

The overall initiative structure guided the actuarial work, which was key to guiding the initial recommendations made by the Medicaid Advisory Committee. That work was completed and included in the MAC's report (See Appendix 3). Further work to be completed in our no-cost extension includes ongoing discussion with a health economist to analyze the issue of costs of

[8] *The Medicaid Advisory Committee is statutorily established and is made up of key stakeholders including, but not limited to a licensed physician, representatives from healthcare consumer groups that include Medicaid recipients, the disability community, and Medicaid managed care organizations. The group is established to advise the Oregon Health Policy Commission, OHPR and the Department of Human Services on medical care provided within the scope of the Oregon Health Plan as well as the administration and operation of the medical assistance program.*

uncompensated care versus investment in coverage. This will be an integral report as we enter into the Legislative session both for the discussions regarding the Healthy Kids Plan, as well as the work around expanding access for uninsured adults via the Oregon Health Plan and broader health reform efforts. We will submit the health economist's report by the end of February 2007

### *Efforts Specific to Children's Outreach and Enrollment*

Oregon's RWJF Covering Kids Grant activities have been piloting enhanced enrollment, outreach and retention strategies in four counties around the state for the past three years, and Oregon's HRSA Pilot Planning Activities have built on these efforts during the grant year. Oregon's RWJF Covering Kids grant's steering committee, the Committee on Outreach, Enrollment, and Retention (COER) has worked closely with the Medicaid agency, OMAP, and the premium subsidy program, FHIAP, to improve outreach. They are committed to institutionalizing these improvements to maximize the number of children and their families who can be enrolled in health insurance coverage through either public or private means. OHPR's HRSA team member has been serving as the chair of the COER over this past two years and continues to work with this group to achieve the goals of maximizing enrollment and outreach and to coordinate these efforts with the Governor's Kid Initiative and the design of the Healthy Kids Plan.

The research brief and full report of our *Children's Access to Healthcare Survey* was finalized and released in January 2006 (See Appendix 3). This statewide study was conducted to gather information directly from low-income parents about issues they face when attempting to obtain health insurance coverage for their children. A mail return survey was conducted between April and June of 2005, and included a sample of Oregon food stamp-enrolled families with children between the ages of one and nineteen. Study participants were asked to respond to questions designed to: identify barriers faced by low income Oregon families who qualify for publicly-financed health insurance; examine demographic and other factors associated with barriers to children's health insurance enrollment and continuous coverage; and to explore potential links between children's health insurance status, access to and utilization of healthcare services, financial impacts, and the reported health status of Oregon's children. This study includes descriptive data from completed surveys from parents of 2,681 children. These findings have been shared both nationally at the American Public Health Association meeting in December 2005, and was shared with the Medicaid Advisory Committee and the Senate Interim Legislative Committee on Children's Health in January, 2006. The findings highlight issues Oregon needs to address to maximize enrollment and retention of children in Medicaid.

Both of these activities informed MAC's decision-making as members developed the initial design recommendations for the Healthy Kids Plan. A key aspect of the plan includes facilitated enrollment and partnering with local communities to target outreach to the uninsured, particularly those eligible but not enrolled. The OPHP program will work with the Medicaid agency and OHPR to develop a grant program to provide funding to collaborative community partnerships, representing both local communities and Oregon's diverse minority populations for outreach and to maximize enrollment and retention. There will also be funding to evaluate the success of the outreach efforts and the overall effectiveness of the Healthy Kids Plan at providing access to Oregon's uninsured kids.

*Healthy Kids External Stakeholders Input and Public Meetings:*

The Healthy Kids plan design work was conducted through a public process via the Medicaid Advisory Committee (MAC) and in collaboration with the Oregon Health Policy Commission and the Senate Interim Commission on Healthcare Access and Affordability. Each of these bodies represent a broad range of stakeholders. The MAC has held larger public hearings on similar Medicaid program changes in the past and has significant experience in getting multiple stakeholder input.

**Healthy Kids Public Meetings:** In April and May 2006, the Medicaid Advisory Committee held public meetings in six locations across Oregon. The purpose of these meetings was to introduce the Governor's Healthy Kids initiative and the role of the MAC, to share the MAC's preliminary recommendations, and to solicit public values and experience on the issues of outreach and affordability.

Members of the MAC began each meeting with a quick PowerPoint introduction and then participants were asked to break into facilitated small group discussions. The meetings ended with a large group discussion of the small group activities. First, small groups were asked to examine worksheets that outlined recent Federal Poverty Level guidelines related to family size and to discuss among themselves the cost of living in their particular community and how much families at different income levels could afford to contribute on a monthly basis to insure their child/children. To get deeper into the issue of affordability, participants weighed in on the different kinds of contributions a family could be asked to make, such as monthly premiums, co-pays, co-insurance, and deductibles. The second small group activity was a brainstorming of outreach strategies that would be effective in reaching two distinct populations: low-income families with children that are already eligible for public health insurance in Oregon but are not currently enrolled and higher-income families that likely have had no experience with public health insurance programs.

The public meetings were successful in attracting a wide variety of stakeholders: members of the business community, parents of children with special health care needs, low-income parents with uninsured children, middle-income parents, school teachers and nurses, public health workers, and political leaders.

A special stakeholder meeting was held with multicultural leaders in Portland. This meeting was an effort to begin an on-going conversation about outreach to families in ethnic, racial, religious, and language minority communities. Following this introduction to Healthy Kids, participants agreed to continue meeting with OHPR staff as an outreach strategy continues to evolve.

**Other Stakeholder Input**: **Legislative Efforts**

In addition, the Legislature has established a Senate Interim Health Committee on Children's Health. The HRSA project team has been working closely with Chair Senator Monnes-Anderson and her staff to coordinate efforts between the Governor's Office, the MAC and her committee work throughout the Healthy Kids Plan design process. We presented the HRSA-sponsored background work, primarily our Children's Access Survey findings, our actuarial work and other relevant information at the Children's Health Committee meetings, and have met regularly with Senator Monnes-Anderson as she has crafted her own legislative concept to expand coverage to all of Oregon's uninsured children. Currently, her legislative concept is very similar to that of the Governor's Healthy Kids Plan, and it is yet to be determined if she and the Governor's office

will combine efforts into one potential piece of legislation in the upcoming 2007 Legislative Session.

### *Challenges:*

While the Governor raised the asset limit last year for SCHIP, there were other efforts to maximize enrollment and retention at the close of last legislative session, specifically, extending enrollment to 12 months for children and implementing expanded access to children from 185% to 200% in both FHIAP and Medicaid. The state has started discussions with CMS around these proposed changes as we are renewing our current waiver, with further details of the plan awaiting further Legislative approval and later either State Plan amendment or waiver amendment discussions with CMS.

Planning was delayed due to a change in the leadership of OHPR, with our Administrator being named by the Governor as the new Director of the Department of Human Services. The anticipated Governor's announcement regarding the Kid's initiative was originally planned in early December, so the delay until February had limited our ability to enter into discussions about the Healthy Kids Plan design until after his announcement, so the work was condensed into a very short time frame to meet the agencies' budget development deadlines for the Governor's Proposed State Budget.

With many members of both the Senate and House very supportive of either Senator Monnes-Anderson's Legislative Concept or the Governor's Healthy Kids Plan, it appears there is strong support for this policy option. However, the Governor is up for re-election in November and new revenue sources are likely to be the subject of intense political debate. However, during the last Legislative session and in a recently failed ballot initiative effort, there were plans to fund similar efforts by increasing the tobacco tax. Governor Kulongoski just released his proposal to support Healthy Kids with an $0.84 per pack increase in cigarette taxes on September 25$^{th}$, 2006; this proposal also restored funding for tobacco cessation efforts that had be curtailed during past budget cuts.

### *Next Steps for the Healthy Kids Plan*

As noted above, legislative concepts have been developed and the agencies' program budgets have been submitted for incorporation into the Governor's proposed budget for the next biennium. In October, 2006 there will be further key stakeholder meetings to review and discuss the Healthy Kids Plan. Further implementation planning will continue and if Legislative approval is given during the 2007 Legislative session and with CMS, we anticipate implementation by January 2008.

## ***Other Policy Option Activities:***

The Governor also directed the Executive Branch to address affordability and expanding coverage to uninsured adults. He directed the Oregon Health Policy Commission to continue their work in developing a plan for long-range health reform for the State. Further, the Governor is directing the Oregon Health Services Commission to examine the Prioritized List of Health Services (used in Oregon's Medicaid program, the Oregon Health Plan) for the potential design of a limited benefit package, using the "List," that would provide preventive and chronic disease management care alone. Both of these Commissions are staffed through OHPR and are proceeding in close collaboration with the HRSA-sponsored activities.

### *1. OHP Standard Benefit Design changes to gain more uninsured coverage*

The Oregon Legislative Assembly created the Health Services Commission (HSC) through the passage of Senate Bill 27 in 1989 in the creation of the Oregon Health Plan. The HSC is made up of eleven volunteer members, who are appointed by the Governor and confirmed by the Senate for four-year terms. The members include five physicians (one of whom must be a doctor of osteopathy), one public health nurse, one social services worker, and four consumer representatives. The HSC's charge is to provide a biennial report to the Governor and Legislature to include a list of health services "ranked by priority, from the most important to the least important, representing the comparative benefits to the entire population to be served."

As part of the most recent biennial review of their prioritized list of health services, completed in July 2006, the HSC developed a new prioritization methodology for the first time since the list was first implemented in February 1994. Whereas the previous methodology focused on the needs of an individual, with the highest priority given to life-saving treatments, the new methodology ranks services in an attempt to maximize the health of the population, by placing more emphasis on prevention and services used in managing certain chronic diseases. Some of the services moving towards the top of the list as a result of this reprioritization include maternity care and newborn services, preventive services found to be effective by the US Preventive Services Task Force, and treatments for chronic diseases such as diabetes, major depression, asthma, and hypertension, where ongoing maintenance therapy can prevent exacerbations of the disease that lead to avoidable high-intensity service utilization, morbidity, and death.

A group of stakeholders brought together by the Governor's office is now examining whether this new list could be used to expand coverage to a larger segment of Oregon's population living under the federal poverty level who don't meet categorical Medicaid eligibility criteria (through OHP Standard). Over the last three years OHP Standard has seen its enrollment decrease from a high of over 100,000 to its current level of less than 22,000. This workgroup will identify issues for consideration by the legislature involving trade-offs in benefit coverage should additional revenues not be available for an expansion, potential issues involved in implementing such a benefit package, and whether the principles of the Oregon Health Plan would be followed under such a scenario. Should legislation be passed to allow the use of the new prioritized list to define OHP Standard benefits, the need to obtain the necessary waiver amendments from CMS would mean implementation of such an expansion no sooner than the latter half of 2008.

### *2. Health Policy Commission development of a strategic health plan to aim to cover all the uninsured over next five years*

The 2003 Oregon Legislative Assembly passed House Bill 3653, creating the Oregon Health Policy Commission (OHPC) to develop and oversee 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 Oregon State Legislature and the state Office for Oregon Health Policy and Research (OHPR). Additionally, the Commission partners with health care experts and stakeholders around the state to develop projects focused on improving Oregonians' health status and access to effective and efficient health care services.

In early 2006, the Health Policy Commission began to explore broad health reform ideas and evaluate promising ways of making health care more affordable and accessible to all. The goal is a report with recommendations directed at the Governor and the Legislature. In February,

Governor Kulongoski provided the Commission with very specific direction on this work, directing the OHPC to develop recommendations for establishing a system of affordable healthcare that is accessible to all Oregonians. The Commission spent the spring and summer designing the components of its reform plan. While that work continues, the Commission is also estimating costs and drafting a report that will propose concrete reforms and set manageable goals for system change over the next five years. The report will be presented to the Governor in early 2007 and there is close collaboration with the Senate Interim Committee on Healthcare Access and Affordability who are considering their own broad health reform efforts that may be introduced during the 2007 Legislative session.

The HPC maintains a several workgroups (Delivery System Models, Quality and Transparency, Childhood Obesity Study) that are developing recommendations for reform that will be used by the Commission in the drafting of its reform report. The Health Policy Commission has also been regularly updated on the development of the Healthy Kids Plan activities, and incorporated that potential policy option into their thinking on a reform plan.

Also in 2006, the Commission held a meeting with the various groups working on health reform in the state. These groups include multiple ballot initiative efforts and former Governor John Kitzhaber's Archimedes Movement. Out of this meeting a health reform coordination group was formed. The group meets monthly and allows the staff of various reform efforts to keep informed about the work of groups across the state. The coordination group has developed some common messages and shares information and resources wherever possible.

## Activities 3 and 4:

## Development of Better Measures of Access to Health Coverage:

### *1. The Oregon Healthcare Indicator Project.*

Building on the initial efforts started under last year's HRSA supplemental funding, Oregon is completing the Healthcare Indicator Project (HIP), which will provide some technical assessment measures for the state as a whole and individual communities. Through our no-cost extension, we will be able to complete and provide a full report by February 2007. The HIP completed a major revision of the proposed list of indicators of health care capacity and demand. This included an extensive literature review; proposed indicators that lacked an adequate evidence-base were dropped from further consideration. A panel of regional and national experts was then convened to rate the importance of each proposed indicator and the feasibility of comprehensive data collection at the sub-county level. These ratings were used to further refine the indicator list, which is in the process of being more widely distributed for local review. Ultimately, the review process will result in a core set of indicators that measure health care capacity and demand.

In addition, HIP also convened meetings in several urban areas of the state for input. For example, a meeting of stakeholders in Bend, Oregon, a community that is becoming increasingly popular as a retirement destination and is currently the sixth-fastest growing metropolitan region in the United States. Stakeholders reported a harsh healthcare access reality: aside from safety net clinics, no Bend physicians are accepting Medicare patients and many are refusing to accept patients over age 50. Thus, an important indicator of health care capacity for this community is the number of providers accepting Medicare. As HIP convened stakeholder meetings in more communities during this past year, additional community-specific indicators were proposed and adopted. A more detailed summary of the work of the HIP is in Appendix 3.

In concert with the HIP, the Oregon Health Policy Commission (OHPC) has been convening a Local Delivery System Models work group to foster support for community initiatives to improve access to health care. The first project of the group was to survey current community efforts, highlight their progress and lessons learned, and identify initial recommendations about how the state can best help to support these initiatives. A graduate intern assisted the work group, interviewing key representatives in five communities around the state. A final report from that research was submitted to the OHPC in January.

Dovetailing with the work group activities, many members of the Local Delivery System Models work group also held a bi-state summit in December 2005 on local health care access projects with community representatives in Washington State. This summit was viewed as extremely successful in connecting individuals engaged or interested in similar local efforts across the two states. As a next step coming out of that conference, the Northwest Health Foundation, a local health-focused foundation, is released a Request for Proposals to provide meeting facilitation to assist a few communities further develop their local access collaboratives. The OHPC is working in close collaboration with the Foundation's efforts, anticipating that those selected communities will also benefit from our HRSA-sponsored technical assistance and healthcare indicator benchmark work. This collaboration would ensure external stakeholder involvement early in the processes.

*Challenges:*

Our survey of the community models projects in Oregon revealed that several of the initiatives are still very early in their formation. There were not two models ready for the technical assistance as we outlined in our original grant project matrix, although eventually the HIP benchmarks may be feasible as they are being designed with some discussion of broadly available data sources. However, individual community data is limited, depending on the site. Further work will be required to sort this out, although partnering with the Northwest Health Foundation will likely allow us to continue our efforts to work closely with communities to facilitate community-directed solutions for expanded coverage options.

*External Stakeholders Input:*

These activities were constructed with significant external stakeholder input. The HIP has and continues to meet with key leaders of the communities to develop the benchmarks, and in close collaboration with the Office of Rural Health. Their work has also been reviewed by the Oregon Health Policy Commission's Local Delivery System Models workgroup early in its inception with frequent updates.

The Local Delivery System Models workgroup has broad representation as participants, and the bi-state conference had significant attendance from throughout Oregon, both community and state leaders, as well as legislators. All future steps will continue to have wide stakeholder input.

## *2. Review and Improve the Oregon Population Survey*

Oregon monitors health insurance coverage in the state through a biennial statewide random digit dial (RDD) survey, the Oregon Population Survey (OPS), sponsored by Oregon's Progress Board. The survey has been fielded consistently since 1990 and has provided reliable, regional data on health insurance coverage since that time. However, with increasing numbers of households in the state without land lines and the decreasing willingness of the population to respond to a RDD telephone survey, the OPS is experiencing increasing problems with coverage

and response. This has resulted in lowered response rates and less reliable estimates of health insurance status, particularly for Oregon's communities of color.

The Oregon team worked with our consultants, State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, recognized national experts in the design and implementation of complex sampling and weighting methodologies for state health insurance surveys to design sampling and implementation changes in the OPS.

SHADAC completed the work outlined in the grant to review and improve the Oregon Population Survey. SHADAC provided technical assistance to staff in revising the sampling design, creating sampling specifications, and conducting weighting to ensure that sampling specifications supported the OPS project goals. In addition they:

- *Reviewed Survey Weighting approach***:** SHADAC worked with Oregon staff to review the survey weights from the 2004 Survey and to identify potential problems. SHADAC staff reviewed the sampling and weighting documentation from the 2004 Oregon survey to find potential sources of the problem with the 2004 survey estimates of the rates of uninsurance by race in Oregon.
- *Sample Design Revision***:** SHADAC staff reviewed the 2006 survey sample design, and provided consultation and feedback both via email and by telephone in telephone conference calls.
- *Survey Item Revision***:** SHADAC provided consultation and feedback at the request of OHPR personnel relative to the content and wording of health insurance items on the Oregon Population Survey instrument. SHADAC staff participated in more than three conference calls to assist OHPR staff in crafting revisions to or developing additional survey items for the OPS instrument.
- *General Technical Assistance***:** In addition, they have been available to provide OHPR technical assistance questions as they arose. The 2006 OPS is currently in the field. We expect that SHADAC will review the contractors weighting procedures as a final element of this contract.

### *Challenges*:

Once contracting issues were resolved between the State of Oregon and the University of Minnesota, there were no challenges related to working with the SHADAC staff. They consistently provided their expertise and technical assistance in a timely and complete manner.

### *External Stakeholders Input*:

OHPR staff met regularly with the OPS Executive Committee, a multi-stakeholder group made up of representatives from state agencies. This group makes all decisions relating to changes in the OPS survey. All SHADAC recommendations were brought forward to this group before final implementation in the survey process. Oregon's Office of Multicultural Health was a participant as the project team considers how best to outreach to racially and ethnically diverse populations in Oregon. The Office's staff was involved in all of the OPS Executive Committee meetings in order to ensure the survey was culturally appropriate. They provided feedback to the vendor about how to best approach interviews with diverse cultural groups. We discussed with the Office of MCH a strategy to increase response, but, after looking at the strategies employed in 2004, decided together that the risk of bias was too great. In 2004, the survey showed an odd bi-

modal distribution of African-Americans by income. We believe this might be the result of some of the outreach approaches used in 2004.

## Activity 5: Multi-state Integrated Database

Oregon intended to participate in this effort initiated by the state of Arkansas, as we had since its inception. The latest set of data from Oregon Population Survey was delayed and thus was not contributed in time due to delays in completing our over-sample of the African-American population analysis. We can now make it available, but the database project has closed down at this time due lack of sustainable funding per recent correspondence.

## Implementation Status

These Pilot planning grants have allowed Oregon to move forward to cover 117,000 uninsured children including an estimated 68,000 uninsured children below 200% FPL through the Governor Kulongoski's Health Kids Plan. We are also positioned to make progress for the 138,000 uninsured adult Oregonians under 100% of federal poverty level (FPL). If enacted, these policy options can restore much of the impact of the past years' cuts and build sustainable programs that can withstand future economic fluctuations. Specifically, the implementation status of the project activities are:

### *Healthy Kids Plan – to provide access to coverage for all of Oregon's uninsured kids*

- Poised to go into the Governor's Proposed Budget and the upcoming 2007 Legislative Session with broad bi-partisan support
- Further implementation planning in progress, so if get Legislative approval could proceed with CMS approval and implement by January 2008

### *Work on revising OHP Standard benefits so can afford to cover more uninsured adults under 100% of FPL*

- Key Stakeholder group convened to review the newly re-organized Prioritized List of Health Services to develop a potential redesigned benefit package focused on preventive and chronic diseases predominately so can afford to cover more uninsured adults under 100% of FPL

### *Work towards broader health reform to increase access to health coverage*

- Oregon Health Policy Commission developing its strategic health reform approach, focusing on adopting aspects of the Massachusetts Reform on top of existing programs of the Oregon Health Plan. Also working closely with other health reform efforts in the state including former Governor Kitzhaber's Archimedes Movement and efforts by the Senate Commission on Healthcare Access and Affordability. Anticipate much discussion in 2007 Legislature and possible legislation

### *Development of better measures of access to health coverage and engage communities*

- *Health Indicator Project Benchmarks*
    - Wrapping up the final benchmark list and working with local communities to gain input and positioning the work as a key component of any coverage expansion options to assist in evaluation and success of potential initiatives
- *Improved methodology for the Oregon Population Survey (OPS) and measures of health coverage*
    - Work completed and the 2006 OPS is in the field, awaiting assessment of the improvements

## Recommendations to the Federal Government and HRSA

These Pilot Planning Grant activities have been an integral component of allowing Oregon to pursue coverage expansion options. The State has been a grantee since the first round of grants in 2000 and is very grateful for the opportunities it has afforded the state. Our initial State Planning Grant helped us preserve the Oregon Health Plan through some extremely tough economic times, and assisted in bringing our premium sponsorship program, FHIAP into our Medicaid/HIFA waiver so could obtain federal matching dollars and expand access. Our continuation grants have led to important evaluations and health services research to inform policymakers, and brought together key healthcare stakeholders to gain consensus on future steps to cover more of the uninsured. As we move forward with Healthy Kids and broader reform, we know we would not have gotten this far without the valuable assistance of the HRSA State Planning Grant. In that context, Oregon's recommendations to Federal Government are:

- **The HRSA State Planning Grant program has provided invaluable resources to states to allow them to plan and design coverage options for the uninsured that otherwise would not have been possible and the Pilot Planning Grant program should be continued.**
- **The Pilot Planning Grant application process was labor intensive, as were the original Planning grant and should be shortened. It is challenging for states to devote the magnitude of staff time required to gather all the information required, and the information is not shared with others beyond those reviewing the grants so the information is usually not usable for others. However, the reporting requirements of the Pilot Planning Grant were vastly more straightforward and a better means of reporting gains from the Pilot Planning grant activities.**
- **Access to expertise such as SHADAC and others involved with the HRSA State Planning Grant program have been key to any success we have had by being a resource for complex issues faced by multiple states, providing analytical technical support, not generally found within state governments. The Federal Government could support further technical assistance opportunities to allow ongoing work with such key expertise consultants.**
- **Partnership with the RWJF State Coverage Initiative (SCI)Program and regular interaction with other HRSA State Planning Grantees has provided valuable networking that allows an avenue to exchange new option ideas, share pitfalls and lessons learned, and allow informed evidence-based decision making by our individual state policymakers. The Federal Government could support ongoing avenues of interaction in collaboration with the SCI Program.**
- **Evidence-based decision making by state and national policymakers is vital, so funding of policy option evaluations is a key piece not well supported at the state or federal level, and private foundation dollars are limited. The Federal Government should consider increased support of health services research and evaluation as states try new approaches to covering the uninsured. Increased funding for translating research back to state and national policymakers should be included as an essential element of any funding for health services research.**

## Appendix 1: Summary of Policy Options

| Option Considered | Target Population | Estimated Number of People Served | Status of Approval | Status of Implementation | Number of People served once implemented |
|---|---|---|---|---|---|
| Public-Private Premium Subsidy Program<br>(State-funded Family Health Insurance Assistance Program (FHIAP) was in place; brought it into Medicaid via HIFA waiver to maximize federal match.) | Low-income employed uninsured<br>▪ FHIAP eligibility increased from 170% to 185% FPL<br><br>FHIAP from 185% to 200% FPL | FY2003:<br>15,000<br><br>FY2004:<br>25,000<br><br>FY2005:<br>25,000 | FY2003:<br>15,000<br><br>FY2004:<br>25,000<br><br>FY2005:<br>25,000 | FHIAP Eligibility moving from 170% to 185% implemented October 2002, but eligibility up to 200% FPL not implemented due to state budget cuts | FY2005:<br>An additional 454 enrollees between 170% and 185%, plus additional 3,000 under 170%, for a total estimate of approx. 4,000 (as of June 2005). |
| Medicaid Expansion for Children and Pregnant Women | Children (up to 19) and pregnant women increased from 170% FPL to 185% FPL,<br>Children (up to 19) and pregnant women from 185% to 200%. | FY2003:<br>1,053<br><br>FY2004:<br>1,580<br><br>FY2005:<br>1,580 | July 2001 – HB 2519, which Directed the State to seek 1115 and HIFA waiver to restructure the Oregon Health Plan (OHP2), folding in FHIAP. Waivers Approved 10-2002. | Eligibility increases from 170% to 185% FPL implemented in February 2003, but eligibility up to 200% FPL not implemented due to state budget cuts. | FY2005:<br>An additional 2,557 children and 438 pregnant women, for a total estimate of approx. 3,000 (As of June 2005). |
| Medicaid Expansion for Adults | Parents, from 100% to 185% FPL and Childless adults (19 to 64) from 100% to 185% FPL. | FY2003<br>5,717<br><br>FY2004<br>11,770<br><br>FY2005<br>11,927 | July 2001 – HB 2519, which directed the State to seek 1115 and HIFA waiver to restructure the Oregon Health Plan (OHP2), folding in FHIAP. Waivers Approved 10-2002. | Not implemented due to state budget cuts. | n/a |
| Financial sponsorship by communities | Lowest income of those eligible for OHP Standard –expansion adults under Medicaid- to assist with premium payment | FY2004:<br>19,500 at 10% FPL premium level | Community-directed initiative with planning starting Fall 2002. | Summer 2003. | Estimated 5,000 people at the $6 premium level had premiums paid and remained enrolled in OHP Standard (as of June 2005). |

| Option Considered | Target Population | Estimated Number of People Served | Status of Approval | Status of Implementation | Number of People served once implemented |
|---|---|---|---|---|---|
| "Healthy Kids Plan"<br><br>Secure state resources and offer families affordable options so that all Oregon children have access to health insurance. | All uninsured children (up to age 19) = 117, 750 | FY 2006:<br><br>225,000 (State sponsored)<br><br>567,000 (Employer-based and individual) | Governor's initiative with Legislative Concept to be considered for Legislative Session beginning in Jan 2007 | Implementation target date, January 2008. | Goal: 95% of the uninsured, with 3 year ramp up<br><br>65% by end of Yr. 1<br>85% by end of Yr. 2<br>100% by end of Yr 3 |
| OHP Standard (Medicaid expansion population) Benefit Design Revision | Uninsured adults under 100% FPL | FY2006:<br>~24,000 remain in OHP Standard program | Under discussion with key stakeholders, with potential Legislative Concept for session starting in January 2007. | Goal: Implement upon Legislative and CMS approval of revised benefit package | Goal: Sustainable number within current budget, potentially 5,000 to 75,000, depending on price of revised benefit package. |
| Large-scale reform over next five years:<br>HPC considering potential for Mass-style reform in Oregon | Uninsured Adults | ~440,000 | Remains in concept form. One of several potential health reform strategies under discussion as we approach Legislative session | Under discussion | Goal: ~440,000 |

## APPENDIX 2: (UPDATED 9/2006) Oregon's Project Management Matrix

**Combined 2005 Limited Competition Pilot Project Planning and Limited Competition Planning Request: Oregon HRSA State Planning Grant**

Legend: Design Team Workgroup-DTW; DHS-Department of Health Services; OHPR-Office for Oregon Health Plan Policy and Research; FHIAP - Family Health Insurance Assistance Program; Governor's Health Policy Group -GHPG; HPC - Health Policy Commission; COW -Children's Outreach Group; DSMW - Delivery System Models Workgroup; OPS - Oregon Population Survey; -

| Action Steps | Timetable | | Responsible Agency or Person | Anticipated Result | Evaluating & Measuring Task Completion |
|---|---|---|---|---|---|
| | Duration | Due | | | |
| **Task 1: Benefit Re-design and Modeling Analysis of Selected Medicaid and SCHIP Populations** (Pilot Project and Limited Competition Planning Grant) | | | | | |
| Step 1: Procure contractors for actuarial modeling, economic analysis and Medicaid waiver consultants | 60 days | 1-31-05 (Completed) | OHPR / Project Director | Subcontracts in place | Subcontracts in place |
| Step 2: Form Design Team Workgroup to look at selected options (subset of DHS / OHPR / FHIAP staff, reports back to the Governor's Health Policy Group / Medicaid Advisory Committee /Health Policy Commission | 30 days | 11-30-05 (Completed) | OHPR / Project Director /Project Manager 1 | Work group formed | Design Team Workgroup, inclusive of all relevant stakeholders, formed |
| Step 3: Review federal and state legal rules / required waivers around potential populations | 90 days | 01-31-06 (Completed) | DTW / Project Director / Special Project Manager | Report Summarizing Findings | GHPG receives summary report to use a s tool in discussions |
| Step 4: Benefit modeling and re-design | 180 days | 04-30-06 (Completed) | Project Director / Actuarial Consultant / DTW / Research Manager / Project Analyst | Report Summarizing Findings | GHPG receives summary report to use a s tool in discussions, presented at Medicaid Advisory Committee (MAC), coordinated with Legis. Committee on Children's Health |
| Step 5: Develop potential benefit package definitions and costs for selected options | 180 days | 04-30-06 (Completed) | Project Director / Actuarial Consultant / DTW / Project Analyst | Report Summarizing Findings | GHPG receives summary report to use a s tool in discussions |
| Step 6: Economic modeling of proposed policy re-design of selected benefit options and its sustainability over time<br>-costs across populations<br>-costs across time<br>-impact to other programs / market / budget | 180 days | 04-30-06 (Completed) | Project Director / Economist / DTW / Project Analyst | Report Summarizing Findings | Report completed and submitted |

| | | | | | |
|---|---|---|---|---|---|
| Step 7: Compile benefit and structure analysis into summary report<br>7a. Content developed by staff and the Medicaid Advisory Committee, incorporate feedback<br>7b. Presentation to GHPG, incorporate feedback<br>7c. Presentation to HPC, incorporate feedback<br>7d. Final summary analysis of re-design and options<br>7e. Final report submitted to Governor | 30 days | MAC report completed 05-31-06 (Completed) | Project Director / OHPR HRSA Team | Report Summarizing Findings 2-4 options for restructuring Medicaid, that include efforts for public/private partnership<br>• Benefit actuarial analysis of each option's benefit package design<br>• Economic modeling of costs of implementing structural/policy design changes and sustainability over time<br>• Assessment of potential unintended consequences/positive benefits of each option | Comprehensive report completed with collaborative effort with Medicaid Advisory Committee and input from GHPG/Health Policy Commission and in collaboration with the Interim Legis. Committee on Children's Health. |
| Step 8: Using final summary analysis, develop work plan for obtaining final consensus on narrowing options to final strategy that would go into waiver amendment | 30 days | 06-30-06 | Project Director / GHPG /OHPR Administrator /HPC Director | Comprehensive Work plan and Healthy Kids Design framework | Consensus by all workgroups members, Gov's health advisor and agency program heads |
| Step9: Develop agency budgets and design implementation plan (waiver approval, systems changes, etc.) | 30 days | 07-31-06 (completed) | Project Director / Project Analyst | Implementation Plan Completed | Implementation plan completed and submitted to GHPG and appropriate agencies |
| Step 10: Develop evaluation plans to study impact of redesign when implemented | 30 days | In progress | Project Director / DTW / Project Analyst / OHREC | Evaluation Plan created | Evaluation Plan completed |
| Step 11: Develop legislative concepts for waiver renewal amendments | 30 days | As of 9-25-06 finalizing | Project Director / HPC Director / Administrator / Special Projects Manager /Project Manager 1 | Concepts created | Concepts completed |
| **Task 2: Maximize Enrollment of Eligible Children** (Pilot Project and Limited Competition Planning Grant) | | | | | |
| Step 1: Form Children's Outreach Workgroup | 30 days | 10-31-05 | Project Manager 1 / Project Director | Work group formed | Workgroup is inclusive of all relevant stakeholders |
| Step 2: Procure contractor for social marketing | 60 days | Activity Not Undertaken | Project Manager 1 | Subcontracts in place | Subcontracts in place |
| Step 3: Summarize the 'lessons learned" from public and private (previous activities) and develop public meetings to gain input into Healthy Kids design | 90 days | April and May, 2006 | Project Manager 1 / Project Director / COW | Report of public meetings to Medicaid Advisory Committee | Report completed and presented |
| Step 4: Identify potential next steps that the state could undertake<br>4a. Presentation to GHPG, incorporate feedback<br>4b. Presentation to the Medicaid Advisory Committee, incorporate feedback<br>4c. Presentation to HPC, incorporate feedback<br>4d. Final summary analysis of re-design and options | 45 days | 05-15-05 (Completed) | Project Manager 1 / Project Director / GHPG / Project Analyst | Prioritized list of findings | Prioritized list completed and incorporated into Healthy Kids design |
| Step 5: Develop a strategic plan and timeline towards implementing those steps – Outreach grant outline developed as part of Healthy Kids | 90 days | 07-31-05 | Project Manager 1 / COW | Preliminary Strategic Plan Finalized | In agency budget prep, need to do more detailed work in |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | implementation phase of HKids |
| Step 6: Work with consultants on social marketing plan - deferred | 90 days | 08-15-05 | Project Manager 1 / Project Director | Social Marketing Strategy Developed | Consensus by all workgroups members |
| Step 7: Develop an evaluation plan for implementation | 30 days | In Progress | Project Manager 1 / Research Manager /Project Analyst | Evaluation Plan Finalized | Consensus by all workgroups members |
| Step 8: Develop legislative concepts for waiver renewal amendments | 45 days | As of 9-25-06 – In Progress | Project Director / HPC / Administrator / Special Projects Manager /Project Manager 1 | Concepts created | Concepts completed |
| **Task 3: Community Models for Universal Coverage** (Pilot Project only) | | | | | |
| Step 1: HPC's Delivery System Models Workgroup updated on Premium sponsorship and other collaborative efforts, initiate conversations | 30 days | 10-31-05 (completed) | Project Director / Project Analyst | Presentation | Presentation to HPC |
| Step 2: Complete inventory of community models currently in planning and/or progress | 60 days | 1-30-05 (delayed from original | Project Director / Project Analyst | Presentation | Presentation to HPC |
| Step 3: Criteria development of communities for modeling-deferred due to community survey findings | 30 days | Deferred | DWMW / Project Analyst / Research Manager | Criteria Developed | Criteria Developed |
| Step 4 Assessment of data availability | 45 days | On-going | Project Analyst | Completed inventory | Inventory presented |
| Step 5: Modeling of 100% Access in 2-3 communities-Deferred | 90 days | Not undertaken | Project Analyst | Modeling completed | Modeling completed |
| Step 6: Summarizing data analysis recommendations and working with local advisory committees | 45 days | 8-31-06 – Still in Progress | Project Director / Project Analyst | Report of recommendations | Presentation to GHPHG and Local Delivery System WG |
| Step 7: Develop strategic implementation plan and complete final Health Indicator Project Benchmarks Report | 30 days | Via No-Cost Extension By Feb, 2007 | Project Director / Project Analyst / Research Manager / HPC Director / Administrator / Special Projects Manager /Project Manager 1 | Report completion | Final Presentation to Local Delivery System WG, Safety Net Advisory Council for input, as well as work with Broad health reform efforts to consider as evaluation method of success |
| Step 8: Report back to HPC | 30 days | 08-31-06 | Project Director / Project Analyst | Presentation | Presentation to HPC |
| **Task 4: Improve Oregon Population Survey** (Pilot Project only) | | | | | |
| Step 1: Procure contract with SHADAC | 60 days | 1-31-05 (completed) | Research Manager | Subcontracts in place | Subcontracts in place |

| | | | | | |
|---|---|---|---|---|---|
| Step 2: Consulting with SHADAC | 90 days | 01-31-06 (Completed) | Research Manager / Administrator / Project Analyst | Identified strategies to ensure accurate surveying / reporting of racial/ethnic minority populations | Sampling and weighting plan completed and presented to OPS Executive Committee |
| Step 3: Work with office of Multicultural Health to develop outreach plan | 60 days | 01-31-06 (Completed) | Research Manager / Administrator | Outreach plan developed | Outreach Plan Implemented |
| Step 4: Consensus | 360 | 08-31-06 (Completed) | Research Manager / Administrator | Strategic plan for 2006 OPS sampling | Consensus on chosen methods |
| **Task 5: Arkansas Multi-State Integrated Database** (Pilot Project only) | | | | | |
| Step 1: Renew license with Arkansas | 30 days | 09/31/2005 (done) | Research Manager | License obtained | License obtained |
| **Task 7: Prepare Supplemental Activities Report for the DHHS Secretary** (Pilot Project and Limited Competition Planning Grant) | | | | | |
| Step 1: Draft and finalize Quarterly Reports in required format | 15 | 12-31-05, 03-01-06, 5-15-06 | Project Director / OHPR HRSA Team | Completed report | Completed report in compliance with federal reporting requirements. |
| Step 2: Draft Supplemental Activities Report in required format | 30 | 08-01-06 | Project Director / OHPR HRSA Team | Draft report | Check draft report for compliance with federal reporting requirements. |
| Step 3: Disseminate Supplemental Activities Report for review | 5 days | 08-01-06 | Project Director / OHPR HRSA Team | PSA and website postings | Confirm that PSA and website postings have occurred as planned. |
| Step 4: Allow comment period. | 15 days | 08-01-06 | Project Director / OHPR HRSA Team | Public comment | N/A |
| Step 5: Review, synthesize and summarize comments on Supplemental Activities Report. | 30 days | 08-31-06 | Project Director / OHPR HRSA Team | Improved final product | Confirm that input has been evaluated and incorporated as appropriate. |
| Step 7: Finalize the Supplemental Activities Report. | 30 days | 09-30-06 | Project Director / OHPR HRSA Team | Final report | Gain GB and GO authorization to print. |
| Step 8: Submit Supplemental Activities Report to HRSA. | 1 day | 09-30-06 | Project Director / OHPR HRSA Team | Satisfied grant obligation | Confirm that final report mailed by due date. |

## Appendix 3: Reports

**Activity 1 and 2 Reports:**

***Healthy Kids Plan***

- Medicaid Advisory Committee Recommendations Healthy Kids Plan: contains all presentations to the Committee and Actuarial work completed **http://egov.oregon.gov/DAS/OHPPR/MAC/docs/HealthyKidsReport.pdf**

- Children's Access Survey Final Report is available at: **http://www.ohpr.state.or.us/DAS/OHPPR/OHREC/Docs/CAHS_FullReport_Final06.pdf**

- Governor's Announcement on Healthy Kids is available at: **http://governor.oregon.gov/Gov/sos2006/kids.pdf**

- Governor's summary documents on Healthy Kids are available at: **http://governor.oregon.gov/Gov/summary_health.shtml and http://governor.oregon.gov/Gov/images/HealthyKidsChartPDF1.pdf**

***Health Services Commission and OHP Standard Design Discussion Summary –*** attached

***Oregon Health Policy Commission –*** Draft Straw Plan attached
Full report won't be available until January 2007

**Activity 3 Reports:**

- ***Health Indicator Project –*** Preliminary summary attached; full report not available until early 2007 and will be forwarded at that time.
- ***100% Access Report is available at:***
  **http://www.ohpr.state.or.us/DAS/OHPPR/HPC/docs/2006/SurveyofCommunityCreatedHealthcareSolutionsinOregon06.pdf**

**Activity 4 Reports:**

- ***Oregon Population Survey*** for 2006 is currently just being fielded, with results not available until early 2007, and full report will be forwarded at that time.

## Health Services Commission
## New Approach to Defining OHP Benefits- 5-24-06

**Why is the Health Services Commission (HSC) looking at this?**

- OHP Standard population has declined from a high of 125,000 enrollees to the current level under 25,000, due to past budget cuts.
- In his State of the State speech, Governor Kulongoski made the expansion of OHP Standard using a reprioritized list a part of his health care reform plan.
- Health Services Commission (HSC) believes the overall health of the state's population could be improved by providing an effective benefit package emphasizing preventive care and chronic disease management to a larger number of people.
- The aim is to better use limited resources to provide services that could avert preventable emergency department visits whether the individual is insured or not.
- This should reduce the cost-shift that occurs when providers charge higher rates to the insured to get compensated for charity care provided to the uninsured.

**What is the Commission doing?**

- HSC is restructuring Prioritized List of Health Services to allow the Legislature the option of a new approach for defining OHP Standard benefits.
- Stakeholder input is being solicited through a written survey of providers and advocates, a series of focus groups, and public testimony at HSC meetings.

**How would this effort lead to a new OHP Standard benefit?**

- The new list will be priced for the 2007-09 biennium and will appear in the HSC's biennial report to the 74$^{th}$ Oregon Legislative Assembly.
- Legislature would presumably draw the funding line for OHP Plus on the restructured Prioritized List at or near equivalent of current level.
- Legislature could draw a second funding line for OHP Standard on same restructured List.
- Savings resulting from defining an OHP Standard package that is less comprehensive than exists currently would be reinvested to cover more people in OHP Standard.
- Would re-establish use of Prioritized List in setting benefits rather than current method of having separate list of exclusions (e.g., vision, non-emergent dental, most DME, PT/OT) overlain on List for OHP Standard.

**What about current OHP Plus?**

- Should have minimal impact on OHP Plus benefit package for children, pregnant women, persons with disabilities, and the elderly.

**What else will need to happen?**

- State statutes will need to be changed and the federal government (CMS) will have to approve the necessary amendments of state's Medicaid waivers in order to have the OHP Standard benefits determined by a second funding line on the new list.

Note: The federal government (CMS) has approved very limited benefit packages for expansion Medicaid populations in other states.

**How soon can changes happen?**

- The earliest implementation of the new list could begin, creating more access to OHP Standard, is July 1, 2008.

**Oregon Health Policy Commission**
**Health Reform Straw Plan**
**As of September 14, 2006**

## OVERVIEW OF APPROACH

**Goal: Affordable, accessible, and efficient health care for all Oregonians that ensures positive outcomes and promotes healthy lives.**

- Develop bold reforms that Oregon can implement over the next five years
- Hold as a principle that everyone contributes to system reform
- Strengthen and build on existing public and private insurance structures
- Recognize a successful plan must integrate cost, quality, transparency, public health
- Complement other reform efforts in the state

## REFORM PLAN COMPONENTS

**Individual Coverage Mandate**

- Bring everyone into the market by requiring everyone to seek out affordable insurance
- Choice of package structure permitted within broad insurance definitions
- Non-participants face penalties

**Health Insurance Exchange**

- Sustainable, voluntary central forum for individuals and small employers to buy health insurance
- Mechanism for pre-tax purchasing and access to subsidies
- Defines selection of available benefit packages
- Encourages employer participation by reducing administrative burden
- "Smart purchaser" emphasizing value-based purchasing, pay-for-performance, cost control
- Provide familiar feel of employer-group coverage but with added benefits of more individual portability and choice

**Public Coverage, Subsidies & Incentives**

- Maximize Medicaid funding for insurance premium subsidies and direct coverage to ensure affordable insurance for lower income individuals (Initial proposal: subsidies to 300% FPL)
- State has interest in value-based purchasing
    - Medicaid coverage would emphasize preventive care and chronic care management
    - Premium subsidies could only be used for plans that promote these services
- Dovetail with new Health Services Commission Prioritized List process where possible

**Employer Contribution**

- All employers pay a per worker fee UNLESS they provide insurance to employees
- Employers not offering insurance are responsible for emergency care costs of uninsured workers

- Seeks to minimize ERISA challenges, strengthen existing markets, reduce cost shift in system

**Integrated in OHPC plan will be:**

- Leverage points for improved efficiencies and cost controls
- Metrics for evaluating success of reform plan
- Public health and health promotion
- Delivery system improvements (e.g., local access collaboratives, safety net)
- Increased quality and transparency
- Sustainable financing

## Preliminary Summary of Health Indicator Project

Full Report to be submitted by February 2007

The Healthcare Indicators Project (HIP) was created to assist with the development of indicators of primary care capacity and demand in urban areas, as well as developing strategies for updating urban primary care service areas (PCSAs). HRSA has already defined PCSAs nationwide by aggregating Zip Code Tabulation Areas (ZCTAs), and the Dartmouth Atlas of Health Care has similarly defined Hospital Referral Regions (HRRs). However, local data sets do not include ZCTA and both HRSA PCSAs and Dartmouth Atlas HRRs are much too highly aggregated to permit detailed community-level analysis of potential differences in primary care capacity and demand. Local stakeholders are interested in data for their own communities, not national or state-level statistics. In addition, the HRSA and Dartmouth Atlas measurements do not necessarily meet community-defined needs.

Stakeholder workgroups were convened to discuss updating the PCSAs and defining indicators of primary care capacity and demand. The baseline PCSAs were those originally created by the Oregon Office of Rural Health (ORH) in the 1986. Consensus at an early meeting was to not change the original methods, but simply update the PCSA boundaries using current data. In the Portland metropolitan area, for example, dramatic population changes resulted in 25 revised PCSAs being created from the 14 original PCSAs. Achieving consensus on the revised PCSA boundaries proved more difficult than anticipated, as the diverse needs of numerous stakeholders had to be balanced against practical and political considerations.

Methods developed by ORH to assess access to primary care services in rural areas were used as a jumping off point for discussions about indicators of primary care capacity and demand in urban areas. Early consensus was to use existing data sources. Stakeholders proposed 181 different indicators; the list was sub-divided into domains and evidence-based references were assigned by a visiting family medicine fellow with extensive experience doing similar work in the UK. The HIP staff then removed proposed indicators that were not feasible, usually those derived from data sources that could not be aggregated at the sub-county level or data that were not routinely collected.

The resulting list of 68 indicators was circulated to stakeholders in order to prioritize and shorten the list. Again, this proved much more difficult than anticipated, as the diverse needs of numerous stakeholders confounded attempts to edit the list. The list was then circulated to regional and national experts for review. These experts not only declined to shorten the list, but suggested additional indicators. Therefore, the HIP staff produced a draft list of ten core population, socio-economic, provider manpower, and health outcome indicators thought to provide a useful and concise description of primary care capacity and demand in Oregon's urban areas.

The core indicators were then mapped with GIS software. Poorer health outcomes tended to be geo-spatially associated with higher proportions of poverty and lower median household incomes; this was particularly evident in the Portland metropolitan area, prompting a Portland State University professor to discuss this topic with a graduate-level health disparities class. A study in New York found that these types of disparities geo-

spatially persist over time[1]. Local stakeholder interest in the project's work continues. The HIP staff is currently working with a stakeholder to assess potential locations for a new FQHC in the Portland metropolitan area. In addition, the HIP staff recently worked with an urban community interested in producing its own maps of health care data.

[1] DeLia D. "Distributional issues in the analysis of preventable hospitalizations." *Health Services Research.* 2003: 38(6), Part II; 1761-1779.