

OREGON MEDICAL ASSOCIATION  
HOUSE OF DELEGATES  
Annual Meeting  
April 25-26, 2009  
Hilton Hotel & Conference Center, Eugene, Oregon

**EXECUTIVE COMMITTEE REPORT A**

Informational

**Administrative Simplification Project/Physician Leadership Taskforce**

1 **Administrative Simplification**

2

3 In April 2008, representatives from Oregon hospitals, health plans and  
4 physician leaders met to discuss opportunities for working together to simplify  
5 administrative processes in the health care system. The meeting was convened  
6 by the Oregon Association of Hospitals and Health Systems, the Oregon Medical  
7 Association and Regence BlueCross BlueShield of Oregon. The goals of the  
8 meeting were to share information about administrative simplification efforts in  
9 other states, identify opportunities and challenges in Oregon, and determine  
10 next steps for moving forward. At the meeting, participants decided to move  
11 forward with a planning phase for an administrative simplification project in  
12 Oregon.

13

14 During the summer and fall of 2008, three workgroups—claims, eligibility  
15 and credentialing—met to determine priorities for addressing administrative  
16 headaches. Representatives from health plans, physician groups and  
17 hospitals attended regularly and demonstrated a high level of commitment  
18 and collaboration in simplifying administrative processes. This planning  
19 phase ended with the completion of work plans from each of the three  
20 groups.

21

22 The project’s implementation phase was launched in February, 2009. Each  
23 workgroup is addressing the first priorities in their work plans. The Claims  
24 Workgroup is discussing high phone use by physician offices when online  
25 tools are available to complete self-service. The Eligibility Workgroup has  
26 been looking at health plan websites and insurance cards to address the  
27 lack of consistent information about patients’ eligibility and benefits on sites  
28 and cards. Members of the Credentialing Workgroup are examining the  
29 multiple credentialing processes by numerous entities, including health  
30 plans, hospitals and medical groups.

31

32 In the coming months, each group will continue to gather information from  
33 each other and outside sources. By June, the plan is to identify potential  
34 solutions in each of the three priority areas with the goal of making these  
35 solutions more effective and simple and use resources more efficiently.

36

37 **The Merging of Two Activities**

38

39 Several months after convening of the Administrative Simplification effort,

1 OMA, OAHHS and representatives of the insurer community were  
2 approached to participate in a broad effort to gain consensus on issues vital  
3 to the transformation of Oregon’s healthcare delivery system. Two things  
4 soon became apparent; the participants in both efforts were nearly identical,  
5 and the Administrative Simplification effort dove-tailed nicely with the goals  
6 and objectives of this larger effort. OMA’s representative, Dr. Robert A.  
7 Gluckman provides the following update on the Task Force’s activities to  
8 date:

9  
10 **Health Leadership Task Force**

11  
12 Commissioned in the summer of 2008 at the request of the business  
13 community (Oregon Business Council, Associated Oregon Industries, Oregon  
14 Business Association and the Oregon Coalition of Health Care Purchasers), the  
15 Health Leadership Task Force (membership attached) is committed to  
16 developing solutions and actions to keep increases in health care costs and  
17 premiums closer to CPI.

18  
19 In the fall of 2008, the group identified four key areas that they believe will  
20 positively impact both short- and long-term costs. These are: new  
21 reimbursement and payment options, evidence-based best practices, value-  
22 based benefits and administrative simplification. Since then, over 120  
23 individuals have been involved in efforts to identify and implement actions in  
24 each of these areas to help bend the health care cost curve.

25  
26 This report highlights the activities of each of the Health Leadership Task Force  
27 work groups.

28  
29 Value-Based Benefits

30  
31 This group is developing a new “value based” benefit design with the goal that  
32 Plans will offer this benefit to the market by January 1, 2010. This benefit  
33 design will provide a three-tiered level of benefits established according to  
34 proven effectiveness for chronic care management and preference, and supply-  
35 sensitive treatments.

36 The first tier will provide full coverage, with no member co-pay responsibility for  
37 an established set of benefits in the treatment of six chronic conditions:  
38 Coronary Disease, Congestive Heart Failure, COPD, Diabetes, Asthma and  
39 Depression. The covered benefits would include a pre-determined number of  
40 doctor office visits and coverage for specific drugs and diagnostic testing  
41 procedures that have been proven to be effective in managing the treatment of  
42 these chronic conditions. The purpose of tier one benefits is to remove all  
43 financial barriers that might prevent individuals from receiving the  
44 recommended ambulatory care. It is expected that this care will prevent costly  
45 and unnecessary emergency room visits and hospitalizations.

46  
47 The third-tier will provide coverage for health services that have been nationally  
48 recognized as being overused and driven by provider preference or supply  
49 rather than sound, population-based medical evidence. Generally these

1 treatments offer little clinical value at the population level and, at worse, they  
2 can potentially be harmful for patients. These services will continue to be  
3 covered but be subject to a separate and higher deductible, co-insurance, and  
4 stop loss or out-of-pocket maximum.

5  
6 All other currently covered services would be covered in the second tier at the  
7 standard deductible, coinsurance and stop loss that is now in place for most  
8 plans.

9  
10 An important feature of this benefit is the identification of employees with  
11 chronic conditions. For large employers, employees would be required to take a  
12 health risk assessment in order qualify for the enhanced benefits in tier one.  
13 Work is currently underway to determine how employees in small groups could  
14 be identified for eligibility in the chronic care, tier one benefit.

15  
16 In addition, the group is encouraging employers to offer proven smoking  
17 cessation and obesity management programs and strategies to improve the  
18 overall health of employees and prevent illness.

19  
20 The next steps for this group are as follows:

- 21
- 22 • Health Plan staff will determine necessary actions required to implement  
23 this benefit design. (April)
  - 24 • Actuarial consulting firm to provide rating assumptions to price this  
25 benefit. (May)
  - 26 • Identify which plans will be offering this plan effective 1/01/10. (July)
  - 27 • Finalize measures of success. (August)
  - 28 • Obtain approval and introduce into the market. (Fall 2009)
- 29

### 30 Evidence-Based Best Practices

31  
32 The HLTF believes that the use of evidence-based best practices is currently  
33 inconsistent across providers, resulting in patterns of over-use and under-use  
34 of appropriate diagnostic tools and treatments. The consistent use of evidence-  
35 based best practices should lead to reduced costs and improved quality.

36  
37 The Evidence-Based Best Practices Work Group, made up primarily of  
38 physicians, met several times to identify the priority areas for its work. The  
39 group felt it should focus on conditions for which:

- 40
- 41 • Evidence-based clinical guidelines exist, i.e., we do not need to wait  
42 for the development of new guidelines
  - 43 • Practice variation exists within Oregon, or Oregon is an outlier (high  
44 utilization) compared to U.S. benchmarks
  - 45 • Initiatives are already underway within Oregon
  - 46 • There is a major cost impact
  - 47 • There is potential to engage patients in the process
  - 48 • Providers will see a benefit to the use of evidence-based guidelines
- 49

1 As such, the focus of the groups' work will be on deployment of the most  
2 appropriate guidelines and how these guidelines could be readily available and  
3 used by clinicians.

4  
5 The Work Group has recommended that the focus should be on the following  
6 priority areas in the initial phase of its work:

- 7
- 8 • High Cost Imaging
- 9 • Management of Back Pain
- 10 • Primary Care Management of Depression
- 11

12 Other areas were also identified for future work such as care for diabetes,  
13 transitions of care (e.g., hospital to home), post-hospital care of CHF patients,  
14 use of the surgical checklist and end of life care.

15  
16 The Work Group recommends that to support the use of guidelines, we must  
17 engage providers and consumers and build the infrastructure for sustained  
18 effort.

19  
20 The next steps for the workgroup include:

- 21 • Site visit with representatives of the Institute for Clinical Systems  
22 Improvement (ICSI) to discuss the success they have had in supporting  
23 the use of clinical guidelines. (April)
- 24 • After that consultation, the group will develop a proposed infrastructure  
25 and work plan that will support adoption and use of these guidelines  
26 broadly throughout Oregon for consideration by the task force. (May)
- 27 • Work with the value-base benefit design and the payment reform groups  
28 to maximize the likelihood of success. (Ongoing)
- 29

30 Administrative Simplification (*see the information above*)

31  
32 Payment and Reimbursement Reform

33  
34 This group has discussed several different types of potential payment reform  
35 options and is focusing their work in two primary areas.

36 The first area of focus is on the concept of the “medical home.” The group is  
37 looking at ways to enable this concept to deliver its' potential in the  
38 management of patients who are chronically ill.

39  
40 The Health Plans are open to changes in compensation. They are requiring a  
41 sustainable value proposition whereby there is a commitment to reductions in  
42 other health expenditures in order to provide additional front-end funding. Our  
43 group hopes to work with the Academy of Family Practice for Oregon and  
44 interested medical groups to advance this concept. The Academy is considering  
45 developing a possible payment model proposal whereby the practice would  
46 accept a per member per month (pmpm) for all primary care services coupled  
47 with a co-pay for services provided. This amount could replace fee-for-service  
48 payments to the group. The internal compensation system of the group would  
49 have to be aligned with the value proposition in order to make this change

1 financially feasible. It is recognized that each participating group would have to  
2 have a critical mass of patients in order to completely revise its internal systems  
3 and processes, so there may be a need for multiple health plans to participate.  
4 The desired result would imbed the services and behaviors that would  
5 eventually lower medical cost trends.

6  
7 The group has set the following deliverables:

- 8 • Identification of the criteria that should be present to be considered a  
9 medical home. (May)
- 10 • Establish payment mechanisms options. (June)
- 11 • Understand potential accrediting mechanisms that might be utilized.  
12 (June)

13  
14 The second area of focus is in the area of paying for bundled services and pay-  
15 for-performance.

16  
17 This work will build on the work of the Value-Based Benefits and Evidence-  
18 Based Best Practices work groups. In addition, several health systems will be  
19 contacted to see if they would be willing to serve as a Beta site to develop a  
20 bundled price to include re-admission cost for certain procedures. Pay-for-  
21 procedure models in use will also be cataloged. Emphasis will be on sharing the  
22 model and experience rather than the specific dollars involved. Participation  
23 would be entirely voluntary.

- 24  
25 • Initiate a survey of the Sponsor health plans and health systems to  
26 assess the degree of interest in participating in the Beta site  
27 demonstration projects around bundled pricing and/or pay for  
28 performance initiatives. (April)

29  
30 As part of the work in both these areas, the Committee spent March 26 with a  
31 national expert in this field, Dr. Harold Miller. This educational opportunity  
32 helped form the subsequent work plan for the Committee. Dr. Miller was invited  
33 to Portland by the Oregon Coalition of Health Care Purchasers. The Health  
34 Leadership Task Force is a sponsor of this event.

35 The following are members of the Health Leadership Task Force:

36  
37 **Physicians:**

38 Doug Walta, M.D., OHFB Service Delivery  
39 Bob Gluckman, M.D., OMA  
40 Mike Bonazzola, M.D., OHSU Medical Group  
41 Roger Muller, M.D., United Health Care  
42 Craig Fausel, M.D., Oregon Clinic  
43 Greg Fraser, M.D., Mid-Valley IPA  
44 Al Weiland, M.D., Northwest Permanente

45  
46 **Hospitals & Health Systems:**

47 Russ Danielson, Providence  
48 George Brown, M.D., Legacy

- 1 Larry Mullins, Samaritan Health Services
- 2 Roy Vinyard, Asante
- 3 Jim Diegel, Cascade Healthcare Community
- 4 Peter Rapp , OHSU

5

6 **Health Plans:**

- 7 J. Bart McMullan, Jr., M.D., Regence
- 8 Robert Gootee, ODS
- 9 Jack Friedman, Providence
- 10 Andy McCulloch, Kaiser
- 11 Ken Provencher, PacificSource
- 12 Dave Ford, CareOregon
- 13 Chris Ellertson, HealthNet
- 14 Majd El-Azma, Lifewise

MONICA WEHBY  
PETER A. BERNARDO  
JAMES S. HICKS  
JOHN E. EVANS, III  
KLAUS MARTIN  
CARLOS D. SANCHEZ  
WILLIAM C. PIERCE  
CARLA MCKELVEY  
MARY MCCARTHY  
EVA GERMAINE-SHIMOTAKAHARA