



SENATE BILL 419 JOINT INTERIM TASK FORCE
ON HEALTH CARE COST REVIEW



REPORT TO OREGON LEGISLATURE

SEPTEMBER 13, 2018

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September 13, 2018

Senate Bill [419](#) (2017) established the Joint Interim Task Force on Health Care Cost Review to study the feasibility of creating a hospital rate-setting process in Oregon modeled on the process used by the Health Services Cost Review Commission in Maryland. Specifically, the Task Force sought to:

- explore opportunities to limit the growth of health care expenditures in Oregon
- address cost drivers in Oregon, with initial focus on hospital costs
- assess potential impact and feasibility of the Maryland model
- consider and evaluate alternative models to accomplish the goals in Senate Bill 419

The Task Force held ten meetings from November 2017 through September 2018. In accordance with ORS 192.245, the Joint Interim Task Force on Health Care Cost Review is submitting a written report that describes the process and considerations that have guided their work. The report's centerpiece is the recommendation for establishment of a health care spending benchmark – **a statewide target for the annual rate of growth of total health care expenditures.**

Based on comprehensive research and information provided by national and state health policy experts, the Task Force recommends a solution that supports accountability for total costs of care applied to all payers, public and private, and builds on Oregon's existing health care reform efforts around cost containment and payment reform. The Joint Task Force on Health Care Cost Review recommends enhancing the transparency of the state's health care system, identifying and addressing health costs and prices through a public reporting process, and establishing a statewide target for the annual rate of growth to reduce total health care expenditures.

The Joint Interim Task Force on Health Care Cost Review hopes their recommendations and report provide clarity for legislators to move forward in 2019 with an actionable policy framework that aims to create a more affordable and sustainable health care system in Oregon.

Thank you for the opportunity to provide these recommendations.

Sincerely,

Cameron Smith, Task Force Chair, Director, Department of Consumer and Business Services

EXECUTIVE SUMMARY

Background

Senate Bill [419](#) (2017) established the Joint Interim Task Force on Health Care Cost Review to study the feasibility of creating a hospital rate-setting process in Oregon modeled on the process used by the Health Services Cost Review Commission in Maryland. Specifically, the Task Force was directed to:

- explore opportunities to limit the growth of health care expenditures in Oregon
- address cost drivers in Oregon, with initial focus on hospital costs
- assess potential impact and feasibility of the Maryland model
- consider and evaluate alternative models to accomplish the goals in SB 419

This report documents the response of the Joint Interim Task Force on Health Care Cost Review to the legislative direction in Senate Bill 419 and describes the process and considerations that have guided the Task Force's work. It includes recommendations approved by the Task Force to address the directives in Senate Bill 419 and supporting documentation. The report's centerpiece is the recommendation for establishment of a health care spending benchmark—a statewide target for the annual rate of growth of total health care expenditures.

Summary of Task Force Activity

The Task Force initially convened in November 2017 and was directed to submit its final report to the legislature by September 15, 2018. We adopted a formal [charter](#) and set of principles to guide our work, which lasted over a period of ten months with each member contributing over 100 hours. Collectively, the sixteen-member Task Force invested over 1,000 hours into examining the Maryland model, hearing from national and state health policy experts, and working to develop a consensus around a set of recommendations designed to contain health care cost growth in Oregon.

The Task Force worked to assess any opportunities and challenges associated with:

- establishing models of accountable care organizations;
- creating multi-payer and all-payer approaches to transform health care payment; and
- key factors to consider in establishing a statewide benchmark to limit the annual rate of growth in health care expenditures.

Based on comprehensive research and information provided by national and state health policy experts; investigation of payment reform models adopted by Massachusetts, Pennsylvania, and Vermont; robust discussion and debate among members; and a series of detailed Task Force exercises, we recommend moving forward with a model similar to Massachusetts' cost containment approach adapted for Oregon's health care environment.

Task Force Findings

The Task Force opted not to recommend adopting the Maryland hospital rate-setting model at this time predicated on the following:

- The approach focuses on fee-for-service rather than paying for value and fails to align with Oregon’s payment reform efforts including incentivizing prevention and population health services.
- Hospital care is a shrinking proportion of health care spending, and a hospital-based rate-setting system could potentially incentivize out-migration of care from regulated hospitals to unregulated outpatient providers (non-hospital providers).
- Maryland’s rate-setting system is complex and administratively challenging to implement and maintain over time.
- The model requires a federal Medicare waiver to implement (Maryland is the only state to have received this type of waiver since 1977).

Having agreed the Maryland model was not appropriate for Oregon at this time, we considered a comprehensive array of alternative policy strategies that serve to accomplish the goals reflected in Senate Bill 419, which were to explore a range of cost-containment approaches to address the rapid and unsustainable growth of health care costs in Oregon. Starting with investigating the financial conditions of and key cost drivers among Oregon hospitals, sifting through a robust set of policy options from other states, coupled with evaluation criteria, we offer our recommendation for the Legislative Assembly to begin its deliberation. Our report provides a clear set of recommendations with guidance on potential infrastructure and implementation considerations, a tentative timeline, and a consensus-driven solution. The policy proposal offers a mechanism to understand and take action on the cost drivers in health care that includes, but is not limited to, hospitals in an effort to address the total costs of health care in Oregon. Based on Maryland’s experience, we recognize that to truly address the total costs of care, both inpatient and outpatient services need to be addressed simultaneously, using a model that applies to all expenditure and provider types, which is reflected in our deliberations and proposed policy framework. The recommendation also seeks to account for variations in terms of patient mix, geographic regions, and provider types, and further commits Oregon to increasing transparency around price and total cost of care—regardless of payer.

Recommendations and Policy Framework

To respond to Oregon’s health care cost challenges, we are recommending a new approach to achieving a sustainable health care system. This is an Oregon solution, a plan to control total health care expenditures across – *all payers and providers* – by establishing a health care spending benchmark: a statewide target for the annual rate of growth of total health care expenditures. This solution supports accountability for total costs of care applied to all payers, public and private, and builds on Oregon’s existing health care reform efforts around cost containment and payment reform. A foundational underpinning for these efforts is ensuring the long-term affordability and financial sustainability of Oregon’s health care system, for patients and providers. To that end, the Joint Task Force on Health Care Cost Review recommends enhancing the transparency of the state’s health care system, identifying and addressing health costs and prices through a public reporting process, and establishing a statewide target for the annual rate of growth to reduce total health care

expenditures. Recommendations further include a set of building blocks and an implementation blueprint and timeline that seek to balance a sense of urgency with feasibility considerations and are designed to support reducing the annual growth of health care expenditures and enhance Oregon's ability to achieve an affordable and financially sustainable health care system.

The proposal also promotes alignment and coordination with Oregon's current commitment to reducing the rate of growth of costs within Medicaid to 3.4 percent per member per year, creating the state's first health care cost growth target. That current commitment ends in 2022. Following the implementation of coordinated care organizations, the Public Employees Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB) were committed to the same rate of growth by the legislature. Between members of the Oregon Health Plan, PEBB, and OEBB—which collectively cover 1.3 million Oregonians, the state has already set a cost growth target of 3.4 percent for one-third of the population. Establishing a statewide benchmark that serves as the annual growth target builds on Oregon's existing commitment by expanding the cost growth target to all payers and providers.

Lastly, the Task Force recognizes the critical intersection between health care spending and quality. In recognition of the Triple Aim and the relationship between costs and quality, the Task Force recommends closely aligning ongoing health outcome and quality measures, reporting, and benchmarking efforts with establishing an annual rate of growth of health care spending in Oregon ([Senate Bill 440](#), 2015). Furthermore, the recommendation provided in this report should be considered in the context of and complementary to reform efforts underway including but not limited to increasing transparency and spending to 12 percent of total medical expenditures on primary care ([Senate Bill 231](#), 2015, and [Senate Bill 934](#), 2017), pharmaceutical transparency and cost reduction ([House Bill 4005](#), 2018), and advancing alternative payment models, statewide, across payer and provider types.

Call to Action for the 2019 Legislative Session

We are aware that legislators have difficult decisions to make in the upcoming 2019 legislative session. We stand ready to assist you in your efforts to move forward with implementing an actionable policy framework and the charges laid out in moving recommendations that stem from the work of Senate Bill 419—from concept to action. We hope our recommendations and report provide clarity for legislators to move forward with an actionable policy framework that aims to create a more affordable and sustainable health care system in Oregon.

Respectfully Submitted,

SENATE BILL 419 JOINT INTERIM TASK FORCE ON HEALTH CARE COST REVIEW

Senator Lee Beyer

Senator Elizabeth Steiner Hayward

Representative Julie Fahey

Representative Ron Noble

Representative Rob Nosse

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Copies of the report may be obtained by sending an email to
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is also available at [https://olis.leg.state.or.us/liz/201711/Downloads/
CommitteeMeetingDocument/150140](https://olis.leg.state.or.us/liz/201711/Downloads/CommitteeMeetingDocument/150140)



LPRO: LEGISLATIVE POLICY AND RESEARCH OFFICE

Report prepared by Oliver Droppers, Legislative Analyst, Legislative Policy and Research Office on behalf of the Joint Task Force on Health Care Cost Review.

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CHAPTER 1

BACKGROUND AND PROCESS

Senate Bill 419 (2017) established the Joint Task Force on Health Care Cost Review to study the feasibility of creating a hospital rate-setting process modeled in Oregon on the process used by the Health Services Cost Review Commission in Maryland. The Task Force was directed to address but was not limited to:

- a) How such a rate-setting process would impact the accessibility and cost of health services currently provided in this state, promote quality care, and impact overall medical cost containment;
- b) How a rate-setting process would interact with and impact coordinated care organizations, the Public Employees' Benefit Board, the Oregon Educators Benefit Board, other state programs purchasing health care, and other cost-containment efforts;
- c) The potential impact on health insurers;
- d) The likely cost of the rate-setting process;
- e) The potential need for and likelihood of obtaining a waiver of Medicare requirements similar to the waiver obtained by the Commission in Maryland; and
- f) Why similar efforts to create a hospital rate-setting process in Washington and other states failed, were not implemented, or were withdrawn from consideration.

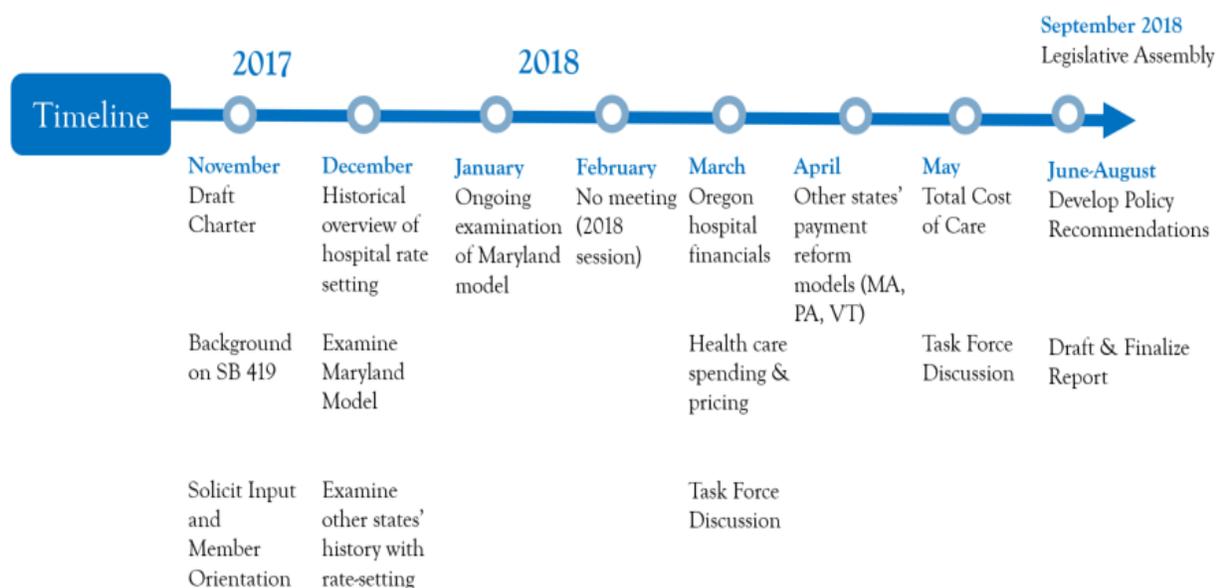
The Task Force began convening in November 2017 and submitted the final report to the Legislative Assembly on September 12, 2018 (see appendix B for complete list of meeting dates, times, and location). The Task Force adopted a formal [charter](#) and set of principles to guide its work, which lasted over a period of 10 meetings with each member contributing approximately 100 hours. In sum, the sixteen-member Task Force invested over 1,000 hours into examining the Maryland model and working to develop a consensus around a set of recommendations designed to contain health care cost growth in Oregon. Twenty national and state experts presented to the Task Force.

Task Force Principles

The principles listed below were adopted to guide the decision-making of the Task Force and in developing and adopting recommendations.

- Promotes hospital financing that is sufficient, fair, and sustainable
- Supports paying for outcomes and value among Oregon hospitals
- Promotes equitable access to care and avoids cost-shifting for all payers
- Achieves better health, better care, lower costs, and improves work life of health care professionals (quadruple aim)
- Aligns with state health reform initiatives and lowers the rate of growth of health care costs

Figure 1. Task Force Timeline



Members of the Task Force agreed to fulfill their responsibilities by attending and participating in Task Force meetings, studying the available information, and participating in the development of a report. Members agreed to participate in good faith and to act in the best interests of the Task Force and its charge.

The Task Force met monthly in Salem at the Capitol. At each monthly meeting, members engaged in a series of conversations with state and national health policy experts, reviewed health care expenditure data and reports, and completed a set of exercises designed to help the Task Force complete its tasks. At their initial November meeting, members discussed the legislative intent with an agreement that the Task Force would initially focus on Maryland; however, they would not limit their work to Maryland's hospital rate-setting model. Members also requested a series of data, information, and reports needed to complete the activities as outlined in Senate Bill 419 (2017) and summarized below.

- General description of the State of Maryland: demographics (health status, age, employment, household income) and economy.
- Maryland health care landscape including the state's hospital delivery system: key characteristics, types of health systems, sizes of health systems, types and number of hospitals, labor environment, insurance carriers, payer mix (Medicare, Medicaid, commercial) (fee-for-service/managed care organizations), regulation of insurance market (rate review and approval process).
- Summary of the state's history with hospital rate-setting: overview of Maryland Health Services Cost Review Commission.
- Description of Maryland's new All-Payer model.

- Performance and impact of rate-setting in Maryland: evaluation, impact, and effectiveness of the original model (through 2013) and new model (2014 federal waiver).
- Oregon health care landscape including the state's hospital delivery system.
- Assess what states have moved away from hospital rate-setting, and why?
- Learn what other states are doing around alternative payment models: Massachusetts, Pennsylvania, Vermont, total cost of care, and other methods for containing hospital costs beyond rate-setting.
- Evaluate data availability, reporting, and transparency of hospital costs in Oregon compared to other states.

Staff assessed requests from the Task Force and structured monthly meetings based on guidance from members. At each monthly meeting, the chair reserved time on the agenda for receiving public comment. Summaries of comments shared in person can be found in the monthly meeting summaries prepared by LPRO staff.

ORIGINS OF RATE-SETTING IN THE UNITED STATES

Senate Bill 419 (2017) required the Task Force to evaluate past efforts to create hospital rate-setting processes in Washington and other states, and understand why such efforts ultimately were discontinued by states over a thirty-year period. Provided below is a brief history of the origins and different types of hospital rate-setting systems that states adopted but no longer operate.

States adopted rate-setting systems in the 1970s as a tool to contain health care costs including state Medicaid expenditures. By the mid-1990s, a majority of states discontinued their rate-setting programs. As of 2018, Maryland is the last state operating a rate-setting commission.

Historical Timeline for Hospital Rate-Setting

- 1965-1979 – Hospital inpatient expenditures (per day) increased 12 percent per year.
- 1972 – Congress passed Section 222 (P.L. 92-603) giving states authority to establish rate-setting programs.
- 1973 Congress passed (P.L. 93-222) to foster development of health maintenance organizations (HMOs).
- 1977 – President Carter proposed federal hospital cost-containment legislation.
- 1978 – Federal “National Hospital Rate-Setting Study” (NHRS).

The primary objective of rate-setting programs was to control health care costs; additional goals were to increase hospital productivity, reduce cost-shifting, and improve access to care for uninsured populations. The country gradually transitioned away from cost-based reimbursement to “prospective reimbursement,” essentially establishing, in advance, a hospital’s limits on reimbursement for services provided in a set period (Coeln, 1981; Anderson 1991). Establishing a payment rate in advance created incentives for hospitals that were absent under the previous cost-based reimbursement model.

The goals of rate-setting in the 1970s were to:

- Reduce rate of growth in hospital costs per capita, reduce average length of stay, number of admissions per capita, or use of non-hospital services.
- Increase levels of hospital productivity.
- Reduce cost-shifting among payers (both all-payer and partial-payer models).
- Improve access to care for uninsured populations; rate-setting systems typically allowed hospitals to receive payments for charity care.

States that adopted rate-setting systems in the 1970s had to consider a number of design questions (Sommers, 2012):

- 1) Scope: all-payer versus partial-payer—would rate-setting be limited to private insurers or also include Medicare and Medicaid?
- 2) Services: would rate-setting apply to inpatient services, or also regulate outpatient and physician services?
- 3) Governance: who in the state would have the authority to oversee and manage the system, and how should it be funded?
- 4) Payment Structure: how to set payment methods per “unit” (paying for episodes vs. individual services) compared to payment “rates” (capping total annual revenue per hospital or revenue per admission).
- 5) Innovation: how will the system support payment innovations (e.g., use of incentives to pay higher rates in return for quality metrics/outcomes)?
- 6) Transition Period: how base rate(s), inflation factors, adjustments among hospitals, and annual updates will be established?

By the late 1970s, prospective rate-setting was a policy tool widely used by states with more than 30 states having adopted different forms of hospital rate-setting with wide variation in both structure and operation. States maintained rate-setting programs through the 1980s. At the same time, the 1980s experienced the rise of health maintenance organizations (HMOs) and preferred provider organizations in the 1990s (McDonough, 1997; Sommers, 2012). Many payers viewed rate-setting as an obstacle to negotiating discounts in a regulated market. Furthermore, the federal government implemented the Medicare inpatient prospective payment system, providing incentives for hospitals to increase efficiency. Nationally, the shift toward deregulation, coupled with the complexities in setting payment rates or regulating payment methods, resulted in a shift away from rate-setting. By the mid-1990s, the majority of states discontinued rate-setting programs with Maryland and West Virginia as the last two states to maintain their programs, with West Virginia discontinuing its program in 2016.

Historical Observations

States that established rate-setting programs experienced variation in terms of the impact on the rate of increase in hospitals costs. For example, Maryland, Massachusetts, New Jersey, and New York experienced decreases in their states’ hospital costs compared to the national average (lowered rate of growth in expense per day and per admission). In contrast, Connecticut and Washington experienced an increase in their states’ hospital costs compared to the national average. During this time period, the country’s health care system evolved from a fee-for-service reimbursement system in the 1960s-1970s to the prevailing prospective payment model that emerged in the 1980s (e.g., diagnosis-related groups (DRG) imposed nationwide by federal Medicare in 1983).

Based on the research, states identified as early adopters were characterized by: (1) increasing Medicaid expenditures, (2) presence of Blue Cross plans with significant market share, (3) higher population densities, and (4) more hospital beds and physicians (Murray & Berenson, 2015). As more states adopted rate-setting models, there was significant variation of rate regulatory systems within individual states, rate-setting methods and formulas changed considerably, and there was an evolution that resulted in “increasingly complex” systems as more states adopted rate-setting models (Murray & Berenson, 2015). As mentioned, the 1980s managed care and capitation payment models emerged as alternatives to containing health-spending growth. A policy question rate-setting states faced in the 1980s was whether to allow HMOs to negotiate discounted rates or require them to pay state-regulated hospital rates (McDonough, 1997). States’ regulatory systems governing rate-setting programs were complex and often modified due to the “changing landscape” (McDonough, 1997). Each state’s move toward deregulation involved a “mix of political, economic, and institutional factors” (McDonough, 1997) that led to a shift from regulation to market-based systems including the health care industry. Based on these factors, among others, there was a “gradual erosion” of support among stakeholders (McDonough, 1997; Murray & Berenson, 2015).

Key Features of Rate-Setting

According to Frankford and Rosenbaum (2017), key features of hospital rate-setting are:

- periodical updating of rates including allowing for adjustments to account for costs beyond a hospital’s control and volume adjustments (limits incentive to increase service volumes);
- inclusion of all payers, which creates incentives for hospitals to reduce costs;
- benefit of a federal Medicare waiver;
- rate-setting system should be “simple and transparent” (contrasted with detailed annual budget reviews and approvals by commission);
- stakeholder buy-in, including insurers, providers, and hospitals; and
- flexibility to evolve and develop new payment approaches.

CHAPTER 3

HISTORY OF HOSPITAL RATE-SETTING IN MARYLAND AND HEALTH SERVICES COST REVIEW COMMISSION

Robert Murray, former executive director of the Maryland Health Services Cost Review Commission (HSCRC) and a nationally recognized expert on rate-setting, joined the Task Force in person in Salem (see Dec. 15, 2017 [presentation](#)). Mr. Murray provided a comprehensive overview of the HSCRC including the background and rationale for the hospital rate-setting program in Maryland including the state's initial startup period and early experiences (1974-1977). Mr. Murray also described Maryland's experience with hospital rate-setting across multiple decades, including key issues that arose, which led the state to reform its approach to rate-setting in the 1990s and 2000s. Mr. Murray also provided a description of different payment models for hospitals and categories of costs (i.e., payment system) and covered the original legislative intent and goals for the HSCRC, which were: (1) control rapid cost growth, (2) improve access to care, (3) make an equitable system, (4) provide accountability and transparency, and (5) ensure financial stability and predictability for hospitals and patients. The Maryland program was originally based on a public utility model of regulation, governed by a commission with seven commissioners appointed by the governor.

Mr. Murray reported that Maryland sets hospital rates for employer-sponsored health plans (Employee Retirement Income and Security Act, often referred to as ERISA plans). Self-funded plans through ERISA coverage are required to reimburse hospitals in accordance with the rates determined by the HSCRC. The United States Supreme Court upheld the authority of state-based regulatory authorities to set rates for ERISA-funded plans.¹ Recently, Maryland has addressed the issue of decreasing inpatient services and increasing outpatient services by moving towards a global budget model with specific incentives created by the states to account for the issue. An important aspect of the Maryland model is that the Commission retains the authority to rebase a hospital's budget if the individual hospital is identified as intentionally moving services to outpatient settings that are unregulated by the HSCRC (e.g., ambulatory surgery centers or diagnostic labs). Capital costs for hospitals has been a continued source of debate in Maryland. Historically, the rates set by the HSCRC include capital costs as a factor. Recently, hospitals and health systems have identified pharmaceutical spending as a significant cost driver.

Mr. Murray described the Commission, its staff, and relationship to the commissioners with more than 40 staff as of 2017. Commissioners serve four-year terms and can be appointed to two consecutive terms. The Commission has expanded its system to a total cost of care model that goes beyond inpatient expenditures to include long-term services, ambulatory services, and other non-

¹ 1 New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co., 514 U.S. 645 (1995)

hospital-related health care expenditures. The state's new rate-setting model is moving toward a population-based methodology or approach in terms of determining total costs of care in Maryland. Mr. Murray also commented on the likelihood that states would be able to negotiate a financially favorable waiver with the federal government similar to Maryland's arrangement. Mr. Murray further commented that through a waiver process, it is unlikely that Oregon, or any other state, would be able to negotiate a large upfront financial investment from the federal government similar to Oregon's arrangement in 2012 with its Medicaid 1115 waiver, and offered Vermont as a recent example.

Mr. Murray also briefly shared that based on analysis conducted for the Oregon Association of Hospital and Health Systems (OAHHS), Oregon should be cautious with respect to the number of small and rural hospitals in the system as it is important not to transfer too much risk to the smaller hospitals. Mr. Murray also mentioned the impact of hospital consolidation, the impact on medical charges, and the degree of consolidation in Oregon compared to Maryland. The implicit goal for Oregon, according to Mr. Murray, should be to discourage consolidation among hospitals and to focus and place emphasis on prevention and primary care services. He also briefly discussed the payment or reimbursement differential among payers in Oregon compared to Maryland. Mr. Murray concluded his presentation by sharing his perspectives on the advantages and disadvantages of hospital rate-setting based on Maryland's more than four decades worth of experience. Below are advantages and disadvantages of rate-setting approaches (Mr. Murray [presentation](#), slides 45-46).

Advantages of Adopting a Hospital Rate-setting Approach

- Well-developed and flexible rate-setting systems experienced success in the 1970s and 1980s
- Potential to control 36 percent to 38 percent of health care spending and achieve other goals (i.e., improve the equity, access and overall stability and transparency of the system)
- Could provide a starting point for broader control of total cost of care (TCOC) increases for Medicare initially and potentially all payers
- Elements of rate-setting could be implemented on a regional basis
- Vermont is attempting to implement hospital Global Budgets under a statewide accountable care organization (ACO) approach

Disadvantages of Adopting a Hospital Rate-setting Approach

- Enormous effort (garnering of necessary intellectual capital and the development of a viable and effective regulatory infrastructure is very tricky); no guarantee of success. as evidenced by other states' experiences
- Even systems that were successfully implemented with a Medicare waiver, failed (New York, Massachusetts, New Jersey and Washington)
- Concerns about ability to negotiate a Medicare waiver with the current federal administration

- Hospital care is a shrinking proportion of health care spend—concern of encouraging further out-migration of care from regulated hospitals to unregulated non-hospital providers
- Absence of programs with proven track record of controlling TCOC (expect perhaps primary care focused initiatives with robust shared savings program and care management support)

Maryland’s Approach to Hospital Payment

Below is a description of the evolution of Maryland’s approach to containing hospital costs starting with the formation of the state’s initial Health Services Cost Review Commission. For 40 years, the federal government has “waived” federal Medicare rules to allow Maryland to set hospital payments at the state level. The federal “waiver” approved in 1977 requires that all payers—such as Medicare, Medicaid, and commercial insurance companies—pay the same rate for the same hospital service at the same hospital. Among other benefits, the waiver provides Maryland hospitals with stable financing, including funding for services provided to individuals who are unable to pay. By ensuring that Maryland’s hospitals have stable financing, Maryland has been able to ensure that hospital care has been both accessible and affordable, especially in rural communities. In return for the Medicare “waiver,” Maryland is required by the federal government to meet an annual test evaluating the growth of inpatient hospital costs for each hospital stay. The HSCRC reports that as “national patterns and standards of care changed over the years, the waiver test became outdated.” In the past five years, the Maryland model has evolved to a Total Cost of Care model, which the federal government approved in May of 2018.

MARYLAND ALL-PAYER MODEL: 2014 THROUGH 2018

In 2013, Maryland officials and stakeholders negotiated federal approval of a new five-year “Maryland All-Payer Medicare Model Contract.” This model’s success metrics are based on per-capita hospital growth and quality improvement. This fundamentally changed the way hospitals were paid, shifting away from fee-for-service volume towards a focus on total cost of care and increasing hospital payments for quality improvements. The model requires hospitals to make quality improvements, such as reducing avoidable readmissions after a patient is discharged from a hospital. One of the requirements of the agreement was that Maryland develop a model to address the total cost of care for Medicare beneficiaries by 2019.

TOTAL COST OF CARE MODEL BEGINNING JANUARY 2019-2028

In early 2017, the federal government and state officials, with input from Maryland health care leaders, began negotiations for a new model beginning January 2019. The new model must move beyond hospitals to address Medicare patients’ care in the community. Under the new “Maryland Total Cost of Care Model,” Maryland will be expected to progressively transform care delivery across the health care system with the objective of improving health and quality of care. At the same time,

state growth in Medicare spending must be maintained at a rate lower than the national growth rate. The TCOC Model will give the state flexibility to tailor initiatives to the Maryland health care context, and encourage providers to drive health care innovation. The TCOC Model encourages continued care redesign and provides new tools and resources for primary care providers to better meet the needs of patients with complex and chronic conditions and help Marylanders achieve better health status overall.

The new Total Cost of Care Model will leverage the foundation already developed by Maryland for hospitals and build on the investments that hospitals made during 2014 through 2018. Maryland will continue to encourage provider- and payer-led development of Care Redesign programs to support innovation. Maryland is also continuing efforts to implement a new Maryland Primary Care Program, which is intended to bring care coordination and support to approximately 500,000 Medicare beneficiaries and 4,000 physicians. The state will commit its public health resources to support population health improvements that are aligned with model goals and Marylanders' needs.

Maryland's model has progressed from its initial in-patient hospital rate-setting to a more comprehensive population-based health model that includes both in-patient and out-patient costs as the state transitions to a total cost of care model described in the next section.

KEY ELEMENTS OF THE NEW MODEL

The new Total Cost of Care Model begins January 1, 2019 for a 10-year term, so long as Maryland meets the model performance requirements. Key elements of the new model include:

- Hospital cost growth per capita for all payers must not exceed 3.58 percent per year. The state can adjust this growth limit based on economic conditions, subject to federal review and approval.
- Maryland commits to saving \$300 million in annual total Medicare spending for Medicare Part A and Part B by the end of 2023. The Medicare savings required in the TCOC All-Payer model will build off of the ongoing work of Maryland stakeholders, which began in 2014.
- Federal resources will be invested in primary care and delivery system innovations, consistent with national and state goals to improve chronic care and population health.
- The model will help physicians and other providers leverage other voluntary initiatives and federal programs to align participation in efforts focused on improving care and care coordination, and participation in incentive programs that reward those results. These programs will be voluntary, and the state will not undertake setting Medicare and private fee schedules for physicians and clinicians.
- Maryland will set aggressive quality of care goals.
- Maryland will set a range of population health goals.

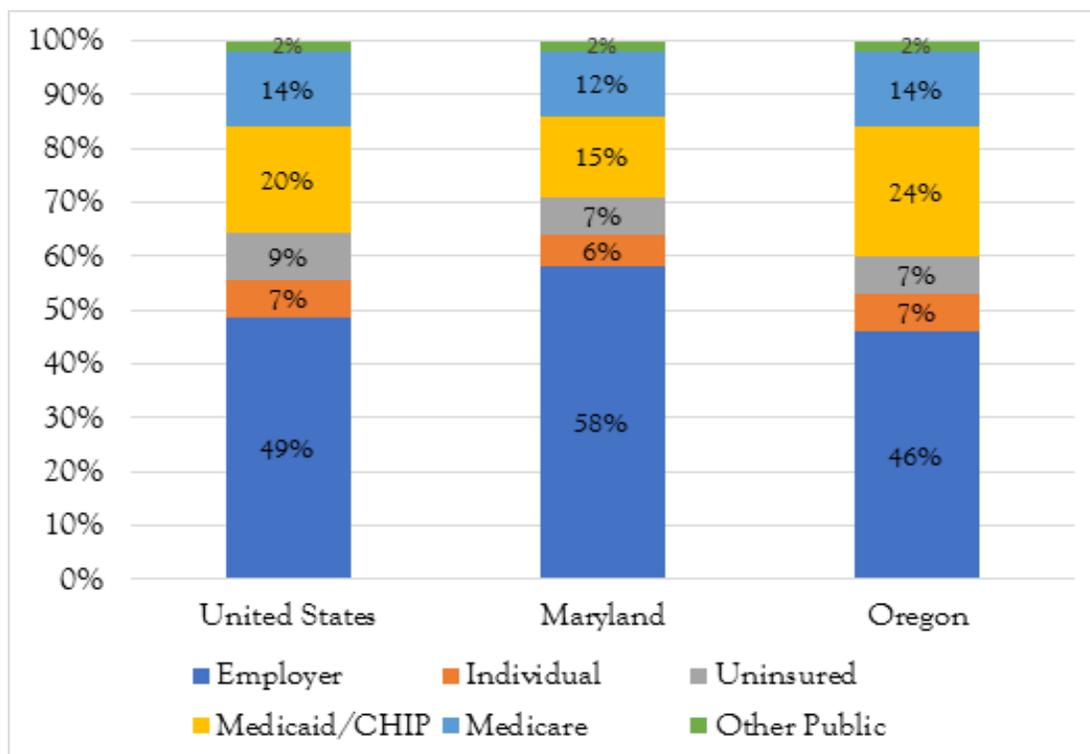
CHAPTER 4

MARYLAND AND OREGON COMPARISONS

The Legislative Policy and Research Office (LPRO) summarized general background information on Maryland and Oregon. Staff presented information on five areas: demographics, health status and coverage, expenditures, data on hospitals, and commercial insurance coverage. This section provides information about the types of health coverage in Maryland and Oregon, enrollment by type of coverage, and expenditures by provider type. Most of the information is post-implementation of the Affordable Care Act (ACA), as both Maryland and Oregon opted to expand Medicaid in 2014.

Maryland has a higher percentage of individuals enrolled in employer-based coverage compared with Oregon, while Oregon has a larger percentage of its population enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). The two states have approximately the same percentage of their respective residents enrolled in Medicare (approximately 15 percent). Figure 2 shows health insurance by coverage type.

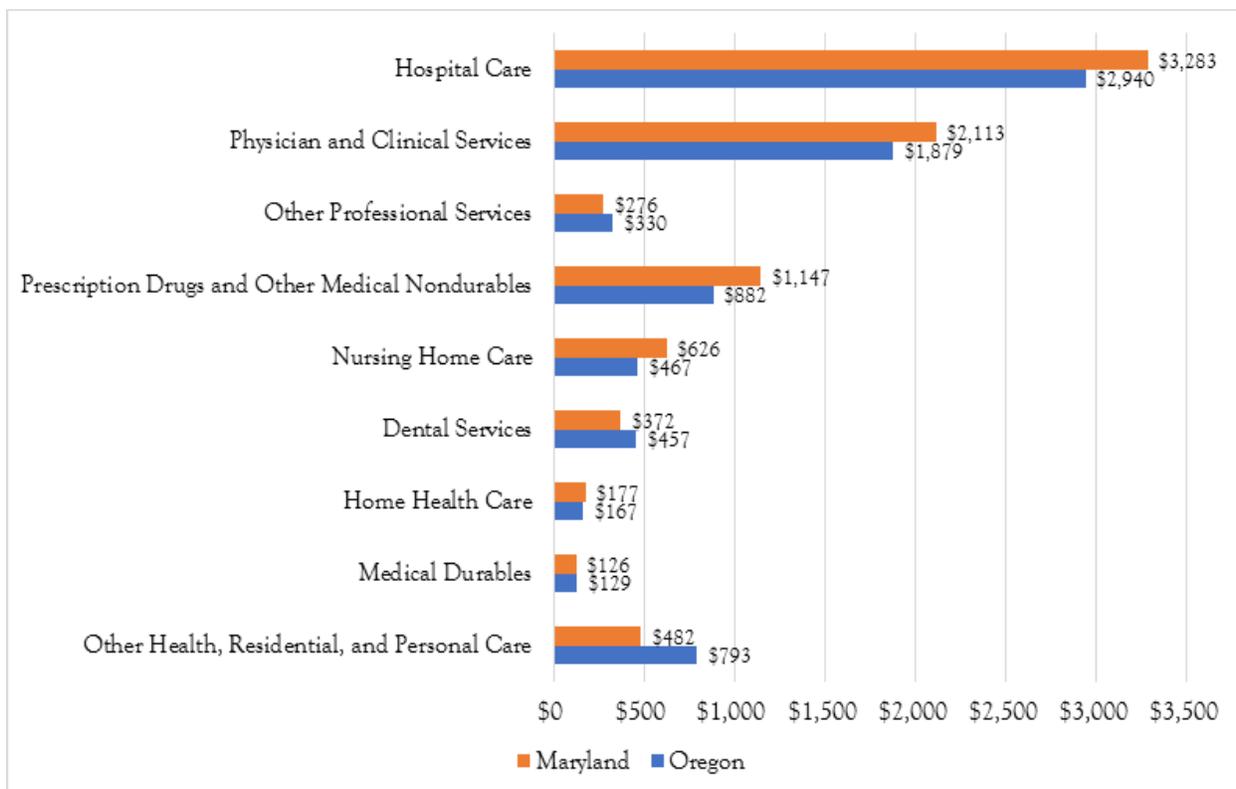
Figure 2: Percent of Population by Type of Health Insurance Coverage



Source: [Maryland Department of Legislative Services](#), State Health Access Data Assistance Center analysis of the American Community Survey; Oregon Health Authority, [Oregon Health Insurance Survey 2015 – Trends in Health Coverage Fact Sheet](#)

The Centers for Medicare and Medicaid Services (CMS) report health spending per capita as including spending for all privately and publicly funded personal health care services and products (hospital care, physician services, nursing home care, prescription drugs, etc.) by state of residence (aggregate spending divided by population). Hospital spending is included and reflects the total net revenue (gross charges less contractual adjustments, bad debts, and charity care). Costs such as insurance program administration, research, and construction expenses are not included in this total. Figure 3 shows health care expenditures per capita by health services in Maryland and Oregon in 2014.

Figure 3: Maryland and Oregon: Health Care Expenditures per Capita by Services (2014) (millions)

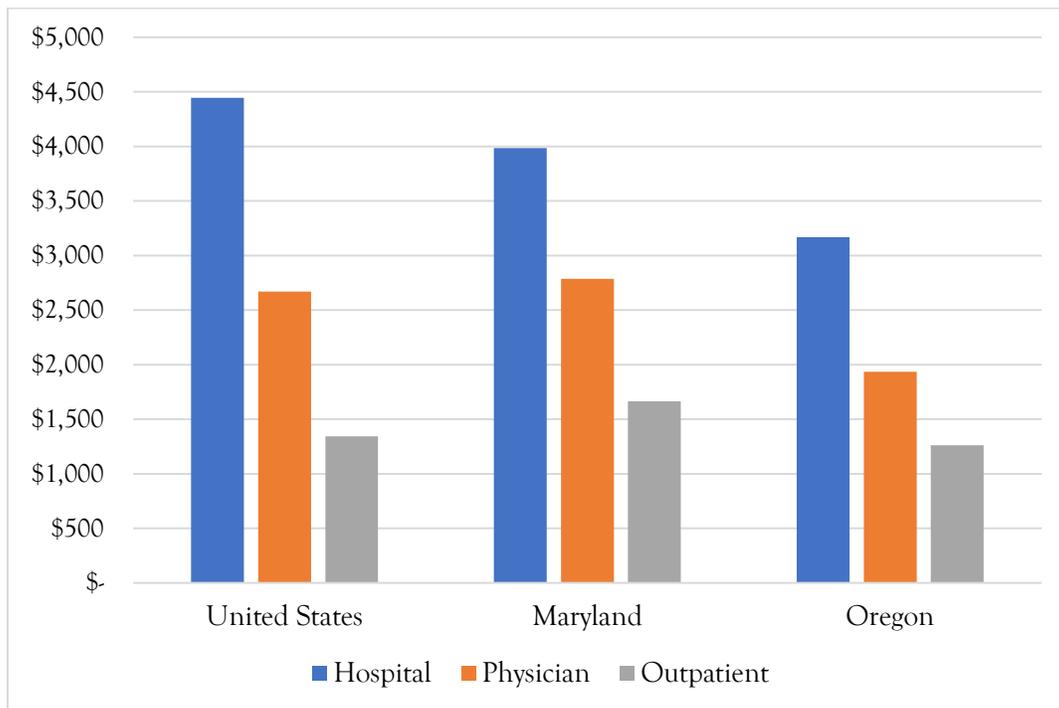


Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

Maryland’s federal waiver with CMS for its hospital rate-setting model and new all-payer model includes a unique waiver for federal Medicare funding. Therefore, it is helpful to compare Medicare funding and reimbursement between Maryland and Oregon. In 2014, Medicare costs per enrollment in Maryland were \$9,126 per enrollee compared to Oregon costs which were \$7,315 per enrollee. In 2014, hospital reimbursements per Medicare enrollee in Maryland were \$3,658 compared to \$3,080 in Oregon both of which were lower than the national average of \$4,243. Similarly, physician reimbursements per Medicare enrollee in Maryland were \$2,811 in 2014, compared with costs in Oregon, which were \$1,963 per enrollee. Maryland’s physician reimbursement per Medicare

enrollee were above the national average of \$2,682. Figure 4 compares the different reimbursement rates for Medicare enrollees in 2014.

Figure 4: Average Hospitals, Physicians, and Outpatient Reimbursements per Medicare Enrollee (2010-2014) in the U.S., Maryland, and Oregon



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

Hospitals

The Maryland Department of Health and Mental Hygiene reports that hospitals are categorized as acute general, psychiatric, chronic, children's, and rehabilitation. The state's acute general hospitals account for 72 percent of all licensed Maryland hospitals. The Oregon Health Authority reports there are 61 acute care hospitals in Oregon, with three different categories of acute hospitals: (1) diagnosis-related group (DRG), which are usually large, urban hospitals that receive Medicare and Medicaid payments based on the prospective DRG system; (2) Type A hospitals which are small and located more than 30 miles from another hospital; and (3) Type B hospitals that are also small but located within 30 miles of another hospital (see [OHA](#)). Of Oregon's 32 Type A and B hospitals, 25 are also designated as Critical Access Hospitals (CAH), which is a designation given to rural hospitals by CMS, in which the federal government compensates CAHs (OHA). Among Maryland's 47 acute hospitals, the state has no Critical Access hospitals. In Maryland, the majority of the hospitals are non-profit and one is a for-profit entity. In Oregon, 58 hospitals are non-profit, and two are for-profit. Tables 1-3 show the number of hospitals, hospital size, and inpatient day expenses in 2015. Figures 5-7 show hospital reimbursement rates from 2010-2014 in the United States, Maryland, and Oregon.

Table 1: Maryland and Oregon Hospital Beds (2015)*

Number of Licensed Beds	Maryland Hospitals	Oregon Hospitals
300 or more beds	7	7
200-299 beds	4	13
100-199 beds	11	12
Less than 100 beds	39	16
Total Beds	9,555	6,664

Source: [DATABANK](#)

Table 2: Hospital Beds per 1,000 Population by Ownership Type (2015) ²

	State/Local Govt.	Non-Profit	For-Profit	Total
Maryland	N/A	2	0	2
Oregon	0.2	1.4	0.1	1.7

Source: Kaiser Family Foundation

Table 3: Hospital Inpatient Day Expenses (2015)³

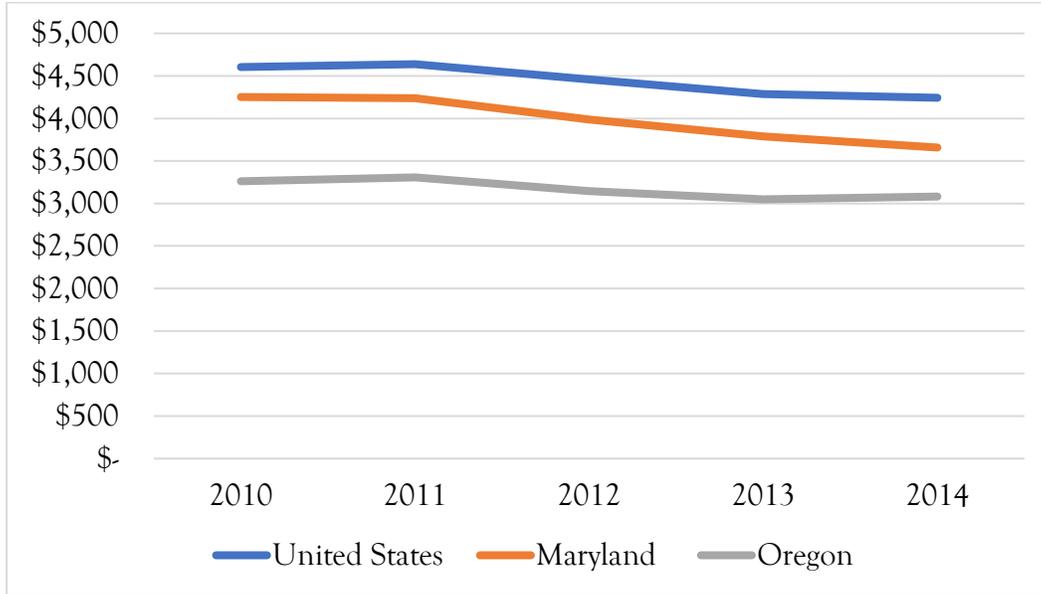
	Expenses per Inpatient Day	Non-profit Hospitals	For-profit Hospitals
United States	\$2,271	\$2,413	\$1,831
Maryland	\$2,514	\$2,521	\$1,108
Oregon	\$3,368	\$3,397	\$2,520

Source: Kaiser Family Foundation

² Data include staffed beds for community hospitals, which represent 85 percent of all hospitals. Federal hospitals, long-term care hospitals, psychiatric hospitals, institutions for people with intellectual disabilities, and alcoholism and other chemical dependency hospitals are not included.

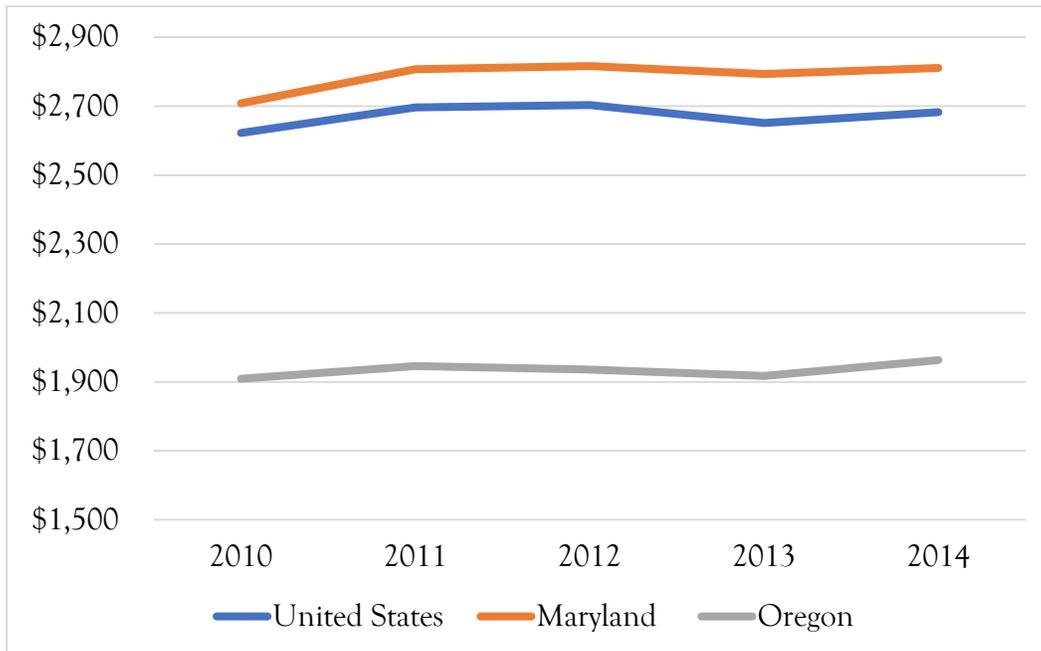
³ Note: includes all operating and non-operating expenses for registered US community hospitals, defined as nonfederal short-term general and other special hospitals whose facilities and services are available to the public. Adjusted expenses per inpatient day include expenses incurred for both inpatient and outpatient care; inpatient days are adjusted higher to reflect an estimate of the volume of outpatient services. It is important to note that these figures are only an estimate of expenses incurred by the hospital to provide a day of inpatient care and are not a substitute for either actual charges or reimbursement for care provided.

Figure 5: Hospital Reimbursements per Medicare Enrollee in the U.S., Maryland, and Oregon from 2010 to 2014



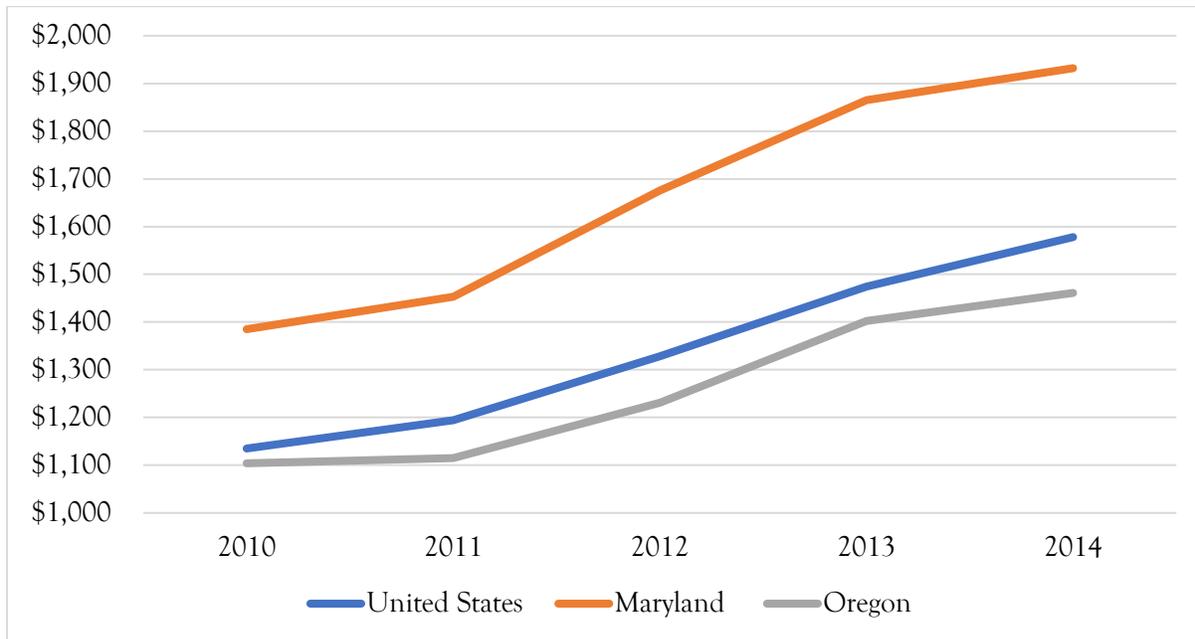
Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

Figure 6: Physician Reimbursements per Medicare Enrollee in the U.S., Maryland, and Oregon from 2010 to 2014



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

Figure 7. Outpatient Reimbursements per Medicare Enrollee in the U.S., Maryland, and Oregon from 2010 to 2014



Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group

Figures 5-7 highlight the differences in reimbursement in Medicare between Maryland and Oregon from 2010-2014 compared to the national average. Based on national expenditure data, Medicare reimbursement for hospital, physician, and outpatient services is considerably higher on a per-member basis in Maryland. This is attributed to the Medicare waiver Maryland received from the federal government in the 1970s and has been successfully renewed for more than four decades. According to Robert Murray, it is estimated that governmental payers pay Maryland hospitals approximately “\$2.3 billion more” than would occur in the absence of Maryland’s Medicare waiver as federal Medicare pays 30 percent higher reimbursement rates (Dec. 15, 2017 [presentation, see slide 12](#)).

CHAPTER 5

OREGON HOSPITALS: FINANCIALS, REPORTING, AND COST FACTORS

The Oregon Health Authority (OHA) was invited to present information on hospital financials and reimbursement in Oregon (see OHA [presentation](#) and [supplemental materials](#)). Staff provided a summary of state and federal hospital designations. In Oregon, there are four hospital types: diagnosis-related group (DRG), and types A, B, and C (see OHA's [hospital handout](#)).⁴ The majority of DRG hospitals are located typically in urban areas, mainly between Portland and Eugene (21 of 27) (see figure 8 on next page). Oregon's type A and B hospitals are rural hospitals with 50 or fewer beds and may be eligible for cost-based reimbursement from Medicare. Type C hospitals are also rural hospitals but have more than 50 beds. There are three federal classifications of smaller hospitals according to the Centers for Medicare and Medicaid Services (CMS): Critical Access hospitals, Sole Community hospitals, and Rural Referral Centers. Two other hospital classifications exist in Oregon: Health District hospitals and Frontier hospitals. Health District hospitals can leverage local taxes to supplement their revenue. Frontier hospitals are on a cost-based reimbursement from Medicaid and receive enhanced reimbursement from Medicare for ground ambulance services.

The Oregon Health Authority presented on hospital funding adjustments based on a hospital's federal and state designation status. A number of hospitals in Oregon receive Medicare payment adjustments including Sole Community Hospitals and Rural Referral Centers designated hospitals. Critical Access Hospitals are exempt from the DRG system and receive cost-based reimbursement calculated by Medicare at 101 percent of reasonable costs. Oregon's eight Sole Community Hospitals receive a 7.1 percent add-on to their CMS payments (see [slide 33](#)). Federal Medicare also offers Medicare Quality Programs, which use financial incentives and penalties to determine reimbursement rates based on quality targets. In Oregon, CCOs can contract with hospitals through a "variety of ways, from fee-for-service, capitation, or a blend of methods" (see [slide 37](#)). Table 4 provides information on the types of hospitals in Oregon along with volume and revenue data.

⁴ DRG, Type A, Type B, Type C, Health District and Frontier hospitals are designated by Oregon statutes.

Figure 8: State and Federal Hospital Designations

	Designation	Number	Description
Oregon Designations	DRG	27	DRG hospitals receive standard Medicare (DRG) based reimbursement. They are typically large urban hospitals.
	Type A	12	Type A hospitals are small hospitals (with 50 or fewer beds) that are located more than 30 miles from another hospital.
	Type B	21	Type B hospitals are small hospitals (with 50 or fewer beds) that are located within 30 miles of another hospital.
	Type C	2	Type C hospitals are rural hospitals with more than 50 beds that are not a referral center. These hospitals are also uniformly DRG hospitals.
	Health District	12	Health District hospitals are hospitals under the control of a formal health district. In most cases the controlling entity of such a hospital is the local county government. Being a part of a health district allows these hospitals access to additional funds from tax sources to contribute to operations. This access to tax funding allows many hospitals to continue to operate in rural areas when they otherwise could not afford to do so. Health districts may also provide funding to other types of clinics and providers.
Federal Designations	CAH Critical Access Hospital	25	Critical Access hospitals are designated by the Centers for Medicare & Medicaid Services (CMS). This designation impacts the reimbursement hospitals receive from Medicare. There are a number of specific criteria a hospital must meet to be considered a Critical Access hospital, but in general it must be located in a rural area and serve patients with limited access to other hospitals. In exchange for providing additional services that it might not otherwise provide due to cost, Medicare will reimburse the hospital at a higher rate than other hospitals receive for the same services. These services mostly relate to expanded emergency services such as a 24 hour emergency room and ambulance transportation.
	SCH Sole Community Hospital	8	Sole community hospitals are rural hospitals located at least 35 miles from another hospital, in which no more than 25% of Medicare beneficiaries are admitted to other like hospitals.
	RRC Rural Referral Center	8	Rural Referral Centers are hospitals that are located in a rural area (with a few exceptions) in which at least 50% of Medicare patients are referrals, and 60% of Medicare patients live at least 25 miles away.
	Frontier Hospital	7	Frontier hospitals are hospitals located in a frontier county, defined as a county with a population density of six or fewer people per square mile.

Source: Oregon Health Authority 2018

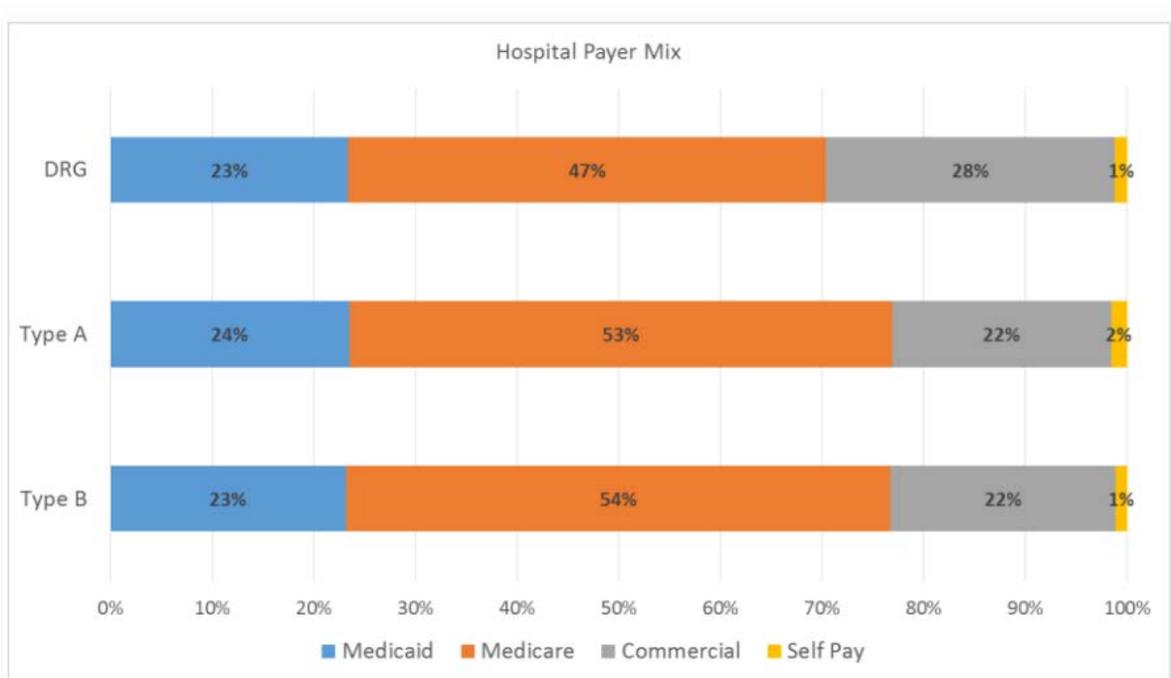
Table 4: Hospital Facts, OHA

Type of Hospital	DRG	Type A	Type B
Number of Licensed Beds	5,765	300	550
Inpatient Occupancy Rate	67%	40%	40%
Inpatient Discharges	312,000	10,500	25,000
Newborns	37,000	2,000	4,800
Emergency Room Visits	1.1 million	95,000	260,000
Median Net Patient Revenue	\$221 million	\$32 million	\$58 million
Employed Staff	41,000	3,300	7,200

Source: Oregon Health Authority, [presentation](#), March 9, 2018

Figure 9 and Table 5 provide information on payer mix and differentials for Oregon hospitals.

Figure 9: Oregon Hospital Payer Mix (2016)



Source: Oregon Health Authority, [presentation](#), March 9, 2018

Table 5: Hospital Payer Differentials

Type of Hospital	DRG	Type A	Type B
Commercial	160%	117%	140%
Medicare	76%	95%	81%
Medicaid	68%	103%	84%

Source: Oregon Health Authority, [presentation](#), March 9, 2018

Materials presented by OHA and Dr. McConnell provided information price variations among Oregon hospitals. Table 6 depicts price variations among a range of hospital procedures and median amounts paid in 2015. Of interest is the range in price variations for services.

Table 6. Oregon Hospital Procedure Price Variations (2015)

Procedure	Median Amount Paid, 2015			
	Min	Median	Max	Max/Min
Coronary Artery Bypass Grafting	\$70,130	\$84,701	\$110,019	1.57
Spinal Fusion	\$24,847	\$47,186	\$64,420	2.59
Knee Replacement (Inpatient)	\$22,000	\$32,231	\$42,203	1.92
Cesarean Section	\$6,690	\$13,791	\$18,280	2.73
Normal Delivery	\$4,108	\$7,848	\$11,546	2.81
Colonoscopy	\$1,311	\$2,764	\$4,123	3.14
CT Abdomen GI	\$255	\$1,086	\$2,512	9.85
Ultrasound	\$230	\$436	\$626	2.72
Mammography	\$117	\$293	\$480	4.09

Source: Oregon Health Authority, Oregon Hospital “Payment Report: Inpatient Procedures 2015,” July 1, 2017

OHA staff provided a summary of payer cost controls and drivers (see Table 7).

Table 7: Payer Cost Drivers, OHA

Cost Driver	Commercial	Medicare	Medicaid
Fee for Service	X		
Case Mix		X	X
Pharmacy	X	X	X
ACA Requirements	X		X

Source: Oregon Health Authority, [presentation](#), March 9, 2018

Based on the financials, reporting, and cost data reported to OHA by Oregon hospitals, the agency identified five opportunities to address cost drivers in Oregon:

1. Address variance in payment
 - Commercial rates, Medicare, and Medicaid
 - Commercial payments among hospitals
2. Address disparities in geographic markets
 - Urban compared to rural
3. Focus on quality outcomes for hospitals and payers
 - Hospitals
 - Payers
4. De-incentivize service volume
5. Incentivize prevention and care coordination

The Department of Consumer and Business Services (DCBS), Division of Financial Regulation, shared [data](#) on inpatient hospital costs among commercial health plans from 2014 to 2016. Among Oregon insurance carriers that report to DCBS, the average inpatient costs have declined from 22.2 percent in 2014 to 20.1 percent in 2016 (per-member, per-month basis). DCBS staff noted that although average inpatient costs have decreased (2014-2016), there is variation with inpatient costs on a per-member, per-month basis across the eight carriers (labeled A-H). Staff commented on unmasking the carrier level data to see geographic differences as currently inpatient costs are masked.

Cost Drivers in Oregon – Task Force Perspectives

Based on the hospital financial information presented by OHA and DCBS in March, LPRO invited Task Force members to respond to an information request. The request was to learn from members about the top drivers of cost growth for hospitals and health systems and what strategies their organizations have undertaken to address the identified cost drivers. The second part of the request was for all non-legislative members to offer their perspectives on the unique circumstances in Oregon that should be considered in developing recommendations that aim to manage the annual growth of health care expenditures. Members submitted responses in writing, which are summarized below. For the questionnaire and individual responses submitted, please see the compiled [responses](#) dated June 15, 2018.

Members that represent hospitals shared their responses to a set of questions on their perspectives regarding health care cost drivers in Oregon. In advance of the meeting, staff sent a two-page questionnaire to non-legislative members of the Task Force (see [written responses](#)). Members representing hospitals identified top drivers of cost or expenses and the effects of these cost drivers (see next page):

- Increasing labor costs and competitive labor market
- Pharmacy costs, particularly specialty drugs
- Technology and capital infrastructure investments (e.g., electronic health records)
- Stagnant reimbursement rates by payers
- Increases in uncompensated care
- Differences in hospital payer mix and composition among commercial, Medicare and Medicaid payers, which impacts revenue and operating margins.

Hospital members also shared strategies they have deployed to address cost drivers that include:

- Salary freezes and reductions in staff/full-time employment
- Decreases in financial investments for capital projects
- Changing care delivery sites, particularly ambulatory settings (e.g., establishing rural health clinics)
- Lowering unit costs and enhancing service utilization
- Shifting employee health care premiums onto employees

Members representing rural hospitals described having limited ability to negotiate payment rates with commercial plans. One aspect mentioned is the charge master and its impact on prices, negotiated discounts among payers and hospitals, rate caps, and revenue for rural hospitals. Another issue raised is price, specifying when discussing “price,” individuals are referring to the amount hospitals are paid for services rendered.

As part of the exercise, members shared their perspectives on the advantages and disadvantages of global budgets for hospitals, all-payer accountable care organizations (ACOs), and a statewide health care cost growth benchmark. Members identified key environmental factors unique to Oregon that included:

- Coordinated care organization infrastructure;
- High penetration of Medicare Advantage plans;
- Patient-centered medical homes;
- Rate review process of commercial carriers by DCBS;
- Differences among urban and rural markets for payers, providers, and hospitals; and
- Oregon’s federal 1115 waiver with CMS.

CHAPTER 6

OREGON HEALTH CARE CONSOLIDATION, SPENDING, AND PRICING

John McConnell, health economist at the Center for Health Systems Effectiveness within Oregon Health and Sciences University (OHSU), presented on Oregon's health care spending (see [presentation](#)). Dr. McConnell reviewed cost drivers in Oregon compared to four other states (Maryland, Minnesota, Utah, and Colorado), as well as price variation across Oregon hospitals (see [presentation](#)). According to Dr. McConnell, commercial prices are high in general as a result of these factors (see presentation [slide 11](#)):

- provider consolidation;
- other sources of market power (e.g., “must-have” status)
- new and costly treatments;
- high cost structures of providers; and
- consumers lack responsiveness to price.

Market Consolidation

Furthermore, Dr. McConnell indicated that Oregon has experienced vertical and horizontal integration (i.e., consolidation) in the provider and insurance markets, specifically, hospitals buying or partnering with physician and ambulatory services, as well as hospitals joining or affiliating with health systems. According to Dr. McConnell, in the past five to seven years, the following mergers and affiliations have occurred (see below). The issue is whether consolidation contributes to higher hospital prices. According to research, consolidation is associated with higher prices and that prices vary substantially across regions, across hospitals within regions, and even within hospitals.⁵ Research indicates that vertically integrated provider markets (i.e., hospital-physician integration) is associated with higher hospital prices and spending for commercial health plans.⁶ In contrast to provider consolidation in Oregon, the state's insurance market remains competitive relative to other states.

⁵ See: Baker, L., Bundorf, M., Kessler, D. (201); Cooper, Z., Craig, S., Gaynor, M., Van Reenen, J. (2015); Neprash, J., Chernew, M., Hicks, A., Gibson, T., & McWilliams, J. (2015).

⁶ Ibid.

Mergers & Acquisitions

- Ascension – Providence St. Joseph Health (2017)
- Providence Health & Services – St. Joseph Health (2017)
- Quorum Health Corp. – McKenzie-Willamette Medical Center (2015)
- Legacy Health – Silverton Hospital (2015)
- Asante Health Systems – Ashland Community Hospital (2012)
- St. Alphonsus Health – Trinity Health (2012)

Affiliations

- OHSU – Adventist Health (2017)
- Providence Health & Services – PeaceHealth (2016)
- OHSU – Salem Health (2015) (*dissolved in 2017)
- OHSU – Tuality Healthcare (2015)

Provider-Insurer Partnerships

- PeaceHealth – Kaiser Permanente NW (2017)
- Legacy Health – PacificSource Health Plans (2015)
- OHSU – Moda (2015)

Dr. McConnell presented on cost-shifting and the difference between that concept and price discrimination. According to Dr. McConnell, recent evidence is not supportive of cost-shifting. In Oregon, due to the expansion of Medicaid starting in 2014, the percentage of uncompensated care among hospitals declined. As the rates of uncompensated care have decreased, there was no decline in patient procedures from 2014-2016. Dr. McConnell explained that empirical evidence from a number of states does not show changes in commercial rates to offset changes in publicly funded insurance programs when payment or reimbursement rates are modified. This can be seen in unit prices when changes in utilization account for lower unit prices. In some cases, a reduction in the public price of services reduced the private price to bring in more private payers to compete.

Addressing Total Cost of Care in Oregon

State health care experts from the HealthInsight, Providence Health Plans, and the NW Primary Care Group provided the Task Force with information about health care affordability and addressing total cost of Care in Oregon (see [presentation](#) and [report](#)). A critical issue experts highlighted is cost and price of health care services in Oregon and nationally which is contributing to an unsustainable growth of health care expenditures with costs defined as allowed amounts that are shared by health insurers and include payments paid by health plans and patients to providers. Staff with HealthInsight shared the history of the Cost of Care Steering Committee (CCS), which was created in 2014, and how the committee has taken a phased approach to transparency and reporting of cost data.

The experts encouraged the Task Force to recognize that the populations covered by Medicare, Medicaid, and commercial health plans differ, and the ability to control costs requires different strategies.

From a comparative standpoint, based on 2015 data from commercial health plans, the report showed Oregon as (see figure 10):

- most efficient in terms of utilization (i.e., resource use) and higher with respect to quality;
- highest in terms of unit cost or price among the five states; and,
- higher prices for inpatient and outpatient services in 2015 than the other states.

According to HealthInsight, in states with lower utilization rates such as Oregon, the “price of services is often increased.” Key is that utilization and price are two critical cost drivers in health care and in Oregon, utilization and price are “working in opposite directions” in which price drives up cost [and] utilization drives cost down.”⁷

Figure 10: Total Cost of Care by Service Category (Commercial Population 2015)

Measure	Colorado	Maryland	Minnesota	Oregon	Utah
Total Cost					
Overall	17%	-16%	7%	0%	-4%
Inpatient	16%	-18%	7%	0%	-1%
Outpatient	30%	-30%	0%	-7%	17%
Professional	5%	-18%	21%	12%	-17%
Pharmacy	24%	7%	-11%	-12%	-8%
Resource Use					
Overall	11%	-3%	5%	-8%	-3%
Inpatient	0%	-7%	8%	-14%	16%
Outpatient	25%	-19%	5%	-16%	13%
Professional	3%	2%	10%	-3%	-13%
Pharmacy	23%	6%	-9%	-10%	-9%
Price					
Overall	6%	-13%	1%	9%	-1%
Inpatient	16%	-12%	-1%	16%	-14%
Outpatient	4%	-13%	-5%	11%	4%
Professional	2%	-20%	10%	15%	-5%
Pharmacy	0%	1%	-2%	-2%	2%

Source: Network for Regional Healthcare Improvement (February 13, 2018). *Healthcare Affordability: Untangling Cost Drivers*

⁷ Network for Regional Healthcare Improvement (February 13, 2018). [Healthcare Affordability: Untangling Cost Drivers](#).

According to HealthInsight, based on the data in states with lower utilization rates, “the price of services often increased” and “limited competition can lead to higher prices” (see [slide 18](#)).

The panel commented that to deal with the cost drivers in Oregon, the state will need to address costs for professional services. The report identified why Oregon’s prices are higher, which is described in table 8.

Table 8. Cost Drivers: Why Oregon’s Prices are Higher

Factors Affecting Commercial Unit Price:	Factors Affecting Utilization:
Provider market power	Health status (morbidity)
Health Plan market power	Physician practice patterns
Cost-shifting	Patient cost-sharing level
Regional cost of living	State mandates
Location of service	Providers in network

Source: HealthInsight, May 11, 2018 presentation to Task Force

According to HealthInsight and state health care experts, to address the cost drivers in health care, the following are necessary: (1) transparency, (2) data and information, (3) changing incentives, (4) community engagement, (5) alignment across sectors, (6) new payment models, and (7) informed consumers (see [presentation](#) May 11).

OTHER STATES' APPROACHES TO COST CONTAINMENT AND PAYMENT REFORM

The initial focus of the Task Force was to examine Maryland's hospital rate-setting model and investigate the state's more recent all-payer model. Based on the legislative history, intent, and direction provided by the legislators serving on the Task Force, members identified a handful of states as potential models for Oregon to explore around cost containment and payment reform: Massachusetts, Pennsylvania, and Vermont. Collectively, the states' models offered alternative approaches to accomplish the goals contained in Senate Bill 419. In 2016, the National Academy for State Health Policy (NASHP) released a report highlighting efforts led by the three states to transition to global budgets and reduce total costs of care (see [NASHP 2016 paper](#)).

Below is a brief description of the policies adopted and implemented by each state. Based on the information provided by each state, the Task Force worked to assess any opportunities and challenges with:

- establishing models of accountable care organizations;
- creating multi-payer and all-payer approaches to transform health care payments; and
- key factors to consider in establishing a statewide benchmark to limit the annual rate of growth.

The next section offers a brief exploration of how policies from the other states may help Oregon reduce the growth of health care expenditures.

Massachusetts Health Policy Commission

The Massachusetts Health Policy Commission (HPC), presented on its state's history and current efforts to address health care cost containment (see [presentation](#) and [2017 cost trends report](#)). In 2012, Massachusetts passed legislation that established the Health Policy Commission and set a statewide target for reducing health care spending growth. The target is set to control the growth of total health care expenditures across all payers (public and private). Total health care expenditures include all medical expenses, non-claims-related payments, patient out-of-pocket expenses, and the net cost of private insurance (see [presentation](#)). A key goal with the all-payer approach was to limit cost-shifting among payers within the state.

In 2012, the state engaged in conversations around a more highly regulated approach, such as creating a statewide rate-setting model similar to Maryland's Health Services Cost Commission. The state decided to rely on the private market to set rates, but did create enhanced government oversight and accountability to oversee the health care market by creating a new agency—the Health Policy

Commission (HPC). The focus of the HPC is to strengthen market functioning and system transparency using four core strategies: (1) research and reports, (2) convening stakeholders, (3) monitoring market performance, and (4) partnering with organizations to advance innovation. In Massachusetts, if an individual provider organization exceeds the benchmark, they are put on a list, referred to the HPC, and are eligible to be required to file a performance improvement plan. As part of the review process, the Commission has discretion to initiate performance improvement plans. To date (2018), no organizations have been put on a performance improvement plan; organizations have been put through the review phase but not all the way through the formal improvement plan.

Since passage of enabling legislation in 2012, the state's health plans, providers, and hospitals have increasingly supported the concept of a cost growth benchmark. Health plans have used the benchmark during their negotiations with providers in establishing reimbursement rates. Areas of restrained cost growth have occurred, particularly in Acute Care hospitals. HPC has the regulatory authority to assess financial penalties (up to \$500,000) if a provider organization fails to complete its performance improvement plan. With increased transparency in Massachusetts, it is assumed that provider organizations have modified their financial behavior. A key part of the transparency process involves an annual hearing over a two-day period in which health care organizations testify under oath as part of public accountability. Interestingly, the state also has a law that requires health care organizations to increase the adoption of alternative payment models. In sum, on average, over the past four years, the state has experienced annual cost growth of 3.55 percent, slightly below the target rate of 3.6 percent, which has resulted in billions of dollars in avoided costs for payers and employers. In the next five years (2018-2022), the state estimates \$4.7 billion in net savings through their program.

Pennsylvania Rural Health Model

Pennsylvania is working to address the financial instability of its rural hospitals and the communities adversely impacted by closures, including loss of access to health care as well as the economic impact on vital employers. As presented to the Task Force in April, Pennsylvania reports that the state's rural hospitals face poor operating margins with nearly half of rural hospitals reporting negative operating incomes in 2016 and 66 percent of these hospitals reporting margins of three percent or less (see [presentation](#) and [background brief](#)). Pennsylvania was not one of the initial states to expand Medicaid through implementation of the federal Affordable Care Act. The state opted to expand Medicaid as of 2016.

In Pennsylvania, the state is working to adopt global budgets designed to help reduce costs and optimize revenues among their rural hospitals which are supported by a multi-payer model including Medicare fee-for-service. Medicaid managed care organizations (MCOs) can voluntarily choose to participate with the long-term goal of transitioning to an all-payer model. In the first year of the model, the state needs to have six hospitals participate with 75 percent of their eligible patient revenue included in their global budget. The goal is to create predictable and stable cash flows and establish incentives to invest in population health among rural hospitals. Pennsylvania is also working to create the Rural Health Redesign Center to support rural hospitals in their transition to

global budgets. As part of the initial assessment process, each hospital conducted financial modeling to understand and assess fixed and operational costs to identify opportunities for cost savings. It is worth noting that there has been a recent trend of mergers and acquisitions among hospitals. The initial hospitals that have agreed to participate in the “rural health model” are mixed in their composition in terms of size and ownership.

Vermont’s All-Payer Accountable Care Organization (ACO)

Vermont has historically experienced increasing health care costs and struggled to improve the health and well-being of its residents. The state established the Green Mountain Care Board (GMCB) in 2011, and then in 2016 with enabling legislation, the state established an all-payer ACO model (see [presentation](#)). Health reform in Vermont has been an evolution, occurring incrementally over time with the GMCB as a regulatory entity helping drive reform in the state. The all-payer system is being pursued in Vermont after the failure of a single-payer effort in 2013. An antecedent to a single-payer system in Vermont is cost-control. In Vermont, the GMCB has the regulatory authority to review and approve both commercial insurers and hospital rates, and conduct certificate of need for hospitals. Vermont officials shared how Medicare participation was critical to promote statewide reform and gain stakeholder buy-in, thus creating the opportunity to promote quality and reduce costs that align across all payers. Specifically, the GMCB sets the state’s Medicare cost growth benchmark and regulates the state’s single ACO.

State Comparisons

To aid the Task Force in working toward the requirements outlined in Senate Bill 419 (2017), the Legislative Policy and Research Office (LPRO) compiled information to summarize policy and programmatic goals among four states: Maryland, Massachusetts, Pennsylvania, and Vermont. Information provided below is based on presentations from and information shared by the individual states as summarized above.

Figures 11-14 are brief descriptions of health reform initiatives for each state organized by six design characteristics (see below). The purpose of the individual state figures is to allow for high-level comparisons across the states to the extent applicable.

1. Payment model and scale
2. Care delivery redesign
3. Financial and quality targets
4. Population health
5. Infrastructure
6. Federal feasibility

Figure 11. Maryland: All-Payer Global Budgets for Hospitals (2014-2018)

Maryland: All-Payer Global Budgets for Hospitals (2014-2018)	
Payment Model and Scale	<p>State determines the total, all-payer revenue target (global budget) for each hospital to decouple revenue from volume and incentivize prevention services</p> <ul style="list-style-type: none"> • Hospitals receive fixed global budgets to shift from volume to value-based payments • All-payer model: Medicare, Medicaid managed care, and commercial payers (including Medicare Advantage)
Care Delivery Redesign	<p>Hospitals transition from fee-for-service to fixed global budgets</p> <ul style="list-style-type: none"> • Funding for enhanced care management initiatives • Funding for quality improvements
Financial/Quality Targets	<p>Limit hospital per capita annual revenue growth 3.58 percent</p> <ul style="list-style-type: none"> • Annual quality/value-based adjustments • Generate \$330 million in Medicare hospital savings over 5-year period • Reduce readmissions to Medicare national average • Reduce hospital acquired conditions by 30 percent over five-year period (65 preventable complications) • Other quality improvement targets (e.g., HCAHPS)
Population Health	<ul style="list-style-type: none"> • Address population health: chronic conditions, deaths from opioid use, and senior health and quality of life (Total Cost of Care, 2018-2022) • Support physicians and other providers who work with high-need Medicare patients through Care Redesign program
Infrastructure	<ul style="list-style-type: none"> • Health Services Cost Review Commission (40 FTE includes economists, statisticians, accountants, legal, staff, & other; \$14.1 annual budget, 100% from assessments) • Robust data collection, reporting, and analytics
Federal Feasibility	<ul style="list-style-type: none"> • Federal Medicare waiver (1977) • Participant in the CMS' Innovation Center • State determines federal Medicare payment amounts to hospitals
<p>Source: Maryland Health Services Cost Review Commission (HSCRC) presentation to SB 419 Task Force, January 19, 2018.</p>	

Figure 12. Massachusetts: Health Care Cost Growth Benchmark (2013-2017)

Massachusetts: Health Care Cost Growth Benchmark (2013-2017)	
Payment Model and Scale	<p>Sets statewide target to control the growth of total health care expenditures across all payers (public and private); sets target to the state's long-term economic growth rate</p> <ul style="list-style-type: none"> • Health care cost growth benchmark for 2013-17 is 3.6 percent (actual is 3.55 percent) • All-payer model includes Medicare, Medicaid, and commercial payers • Strengthens market functioning and system transparency • Promotes efficient, high-quality delivery systems with aligned incentives
Care Delivery Redesign	<p>Health Policy Commission promotes triple aim and innovative care delivery</p> <ul style="list-style-type: none"> • Certifies providers as patient-centered medical homes (PCMHs) and accountable care organizations in MA • Fosters value-based payment • Promotes collaboration and sustained community engagement around whole-person care
Financial/Quality Targets	<p>Enhances transparency of system performance for providers, payers, patients, employers, and state agencies</p> <ul style="list-style-type: none"> • Increase use of alternative payment models by commercial HMO and PPO provider types • Total projected savings 2018-2022 is \$4.67 billion
Population Health	<ul style="list-style-type: none"> • Reduce unnecessary hospital utilization, avoidable emergency department visits and readmission rates (per 1,000 individuals) <ul style="list-style-type: none"> ○ Lower avoidable health care utilization ○ At-risk adults without a doctor visit <p>(see HPC performance Dashboard for list of metrics)</p>
Infrastructure	<ul style="list-style-type: none"> • Health Policy Commission manages all-payer claims database (FTE ~ 60 staff, \$8.5 annual budget, fee-based) • Collects additional provider and health plan data • Robust data collection, reporting, and analytics
Federal Feasibility	<ul style="list-style-type: none"> • No federal participation
<p>Source: Seltz, David (April 20, 2018). Introduction to the Health Policy Commission. Presentation to the Oregon Joint Task Force on Health Care Cost Review. Massachusetts Health Policy Commission (March 2018). 2017 Annual Health Care Cost Trends Report (pgs. 42-43).</p>	

Figure 13. Pennsylvania Rural Health Model (2018-2023)

Pennsylvania: Rural Health Model (2018-2023)	
Payment Model and Scale	<p>Rural hospitals receive global budgets for all inpatient and outpatient services to provide for predictable and stable cash flows</p> <ul style="list-style-type: none"> • Global budgets to cover 90 percent of each hospital’s revenue by year 2 • 30 hospitals will participate by year 3 (45 percent of all rural PA hospitals) • Payers include Medicare fee-for-service, Medicaid managed care, and commercial payers (including Medicare Advantage)
Care Delivery Redesign	<p>Hospitals to redesign their delivery system based on local health needs</p> <ul style="list-style-type: none"> • Hospitals are to build partnerships with other providers through care coordination and referral patterns to promote population health • Hospitals may reduce excess beds, change service delivery lines, or transition operations to outpatient centers • State to review hospital plans to ensure access and quality
Financial/Quality Targets	<ul style="list-style-type: none"> • Estimated \$35 million in Medicare savings • Limit rural hospital cost per capita annualized growth rate to 3.38% across all participating payers
Population Health	<ul style="list-style-type: none"> • Increase access to primary and specialty services • Reduce deaths related to substance use disorder (SUD) and improve access to opioid treatment • Improve chronic disease management and preventive screenings in target areas: cancer, cardiovascular disease, and obesity/diabetes
Infrastructure	<ul style="list-style-type: none"> • Short-term: Department of Health to provide end-to-end assistance at no cost, initially • Long-term: Rural Health Redesign Center to provide technical assistance including data analytics, quality assurance, and other forms of technical assistance (requires enabling legislation)
Federal Feasibility	<ul style="list-style-type: none"> • Participant in the CMS Innovation Center • State determines federal Medicare payment amounts for participating rural hospitals
<p>Source: Hughes, L. (April 20, 2018). Pennsylvania’s Rural Health Model, “Accelerating Health Care Innovation in Pennsylvania.” April 2018 Presentation to the Oregon Joint Task Force on Health Care Cost Review.</p>	

Figure 14. Vermont: All-Payer Accountable Care Organization (ACO) Model (2018-2022)

Vermont: All-Payer Accountable Care Organization (ACO) Model (2018-2022)	
Payment Model and Scale	<p>ACOs designed to incentivize value and quality using single payment structure</p> <ul style="list-style-type: none"> • ACOs receive fixed prospective payments for hospitals; remaining providers on FFS or APMs • Payers include Medicare FFS, Medicaid, and commercial payers • By 2022, 70% of all all-payer beneficiaries and 90% of Medicare beneficiaries enrolled in ACO
Care Delivery Redesign	<p>ACOs to provide a coordinated, system-wide, and integrated reform approach to address Triple Aim through 2022</p> <ul style="list-style-type: none"> • Enhance care coordination • Foster collaboration among community-based providers
Financial/Quality Targets	<p>Transition from volume-driven fee-for-service payment to a value-based, prospective model</p> <ul style="list-style-type: none"> • Limit cost growth target to no more than 3.5% in aggregate across all payers (excludes prescription drugs, dental, long-term care) • Medicare growth target -.1-.2% below national <p>Statewide health outcomes and quality of care targets (as established by the Green Mount Care Board)</p>
Population Health	<ul style="list-style-type: none"> • Improve access to primary care • Reduce deaths due to suicide and drug overdose • Reduce prevalence and morbidity of chronic disease
Infrastructure	<ul style="list-style-type: none"> • Independent Green Mountain Care Board has regulatory authority including payment and provider rate-setting • Existing all-payer claims database, augmented with additional administrative and clinical data sources
Federal Feasibility	<ul style="list-style-type: none"> • Participant in the CMS Innovation Center • CMS investment of up to \$17million first two performance years • Complementary Medicaid 1115 waiver (renewal)
<p>Source: Backus, B., Costa, M. (April 20, 2018). The Vermont All-Payer Accountable Care Organization Model Agreement. Presentation to the Joint Task Force on Health Care Cost Review. Green Mountain Care Board, All-payer Model One-Page Summary</p>	

	VERMONT: All-Payer Accountable Care Organization (ACO) Model	MASSACHUSETTS: Health Care Cost Growth Benchmark	PENNSYLVANIA: Global Budgets for Rural Hospitals
Promote cost containment	<ul style="list-style-type: none"> Gradual transition from fee-for-service to capitation/ACO model Moderate cost containment and cost growth Use of specified goals, trend factors Inpatient and patient focus with hospitals and primary 	<ul style="list-style-type: none"> Policy-driven; targets total cost of care Minimal through establishing growth target benchmark Benchmark applies to all types of expenditures and provider types 	<ul style="list-style-type: none"> Focus is on rural hospital viability and use of incentives to promote cost containment Long-term strategy geared towards achieving all-payer approach to sustainable financing of rural hospitals
Support payment reform	<ul style="list-style-type: none"> Early stages with gradual roll-out and adoption Aligns prospective payments across payers through ACOs Flexibility to use alternative payment models (APMs) and non-traditional health services Leverages the role of managed care in Vermont 	<ul style="list-style-type: none"> Works towards establishing targets for APMs Health Policy Commission (HPC) promotes payment reform through research, public reporting, and promoting investments in new care models 	<ul style="list-style-type: none"> Effective model for payment reform Promising model in its initial stages Innovation may drive payment reform through use of global budgets Payment reform offers stable funding and incentives
Address price variation among payers and providers	<ul style="list-style-type: none"> Limited to enrolled members/capitated lives Aligns payment models across several payers 	<ul style="list-style-type: none"> Establishes a uniform goal with a single target growth rate for everyone Benchmark may reduce price variation among providers and payers over time 	<ul style="list-style-type: none"> Conceptually through use of global budgets Increases investments in population health; potential to lower utilization and decrease profits
Offers multi-payer approach (public & private)	<ul style="list-style-type: none"> Limited, initially to public payers (Medicare and Medicaid) Gradual participation of commercial payers to establish all-payer model 	<ul style="list-style-type: none"> Comprehensive, all-payer Enhanced oversight Quicker movement to APMs Lacking strong enforcement to align payers 	<ul style="list-style-type: none"> Multi-payer except for Medicare; incremental phase-in of commercial payers Voluntary model with use of global budgets among commercial and public payers (Medicaid)
Potential advantages in Oregon	<ul style="list-style-type: none"> Expansion of CCOs to Medicare and commercial members Expand ACO model like Vermont to reduce health care spending Transition from volume (FFS) to value-based payment Allow leverage of Oregon's existing CCO infrastructure 	<ul style="list-style-type: none"> Builds on Oregon's successful 3.4% rate of growth in Medicaid w/CCOs Offers flexibility and a market-oriented solution Accountability by state through reporting, committees, and public hearings Mechanism to review and approve hospital budgets Promotes public accountability with minimal penalties 	<ul style="list-style-type: none"> Moves away from fee-for-service reimbursement model; stable funding and rural health access Focus on rural hospitals may align well w/Oregon's A & B hospitals Offers unique rural health strategies Promotes rural health redesign with CCOs Potential support among payers and providers
Potential disadvantages in Oregon	<ul style="list-style-type: none"> Vermont is significantly different than Oregon (size, single dominant commercial payer) Vermont's experience of failed single-payer Potentially less Medicare funding Administration of policy oversight Limited ability to pay for services outside of ACO model 	<ul style="list-style-type: none"> Administrative complexity of HPC; funding needs Feasibility of establishing a new agency Limited enforcement Incomplete results MA as an outlier; questionable long-term ability to stay below annual growth target 	<ul style="list-style-type: none"> Voluntary basis may be difficult for payment changes Limited usefulness without Medicare participation May not result in system-wide savings Unknown if rural hospitals in Oregon would embrace this payment model Applicability of global budget to non-rural hospitals (e.g., DRGs)

Necessary Conditions: Other States' Approaches to Cost Containment and Payment Reform

Based on the information provided by the other four states, the Task Force requested LPRO to identify if there were any necessary conditions and key drivers that supported cost containment and payment reform. Based on a review of policy literature and policy process, LPRO identified the following conditions: (see [presentation](#) slides 28-30)⁸

I. Assessment that a state's health system is underperforming among key dimensions:

- Access, quality, efficiency, or costs
- Collective and shared urgency in the importance of understanding the sources of cost growth and future health care expenditures, public and private
- Failure of a market-based payment system to control spending and prices, and the need to control spending on health care costs
- Recognition of fragmented modes of payment including different payment systems, provider types and site locations, and provider consolidation
- Identified need to stabilize financing for rural hospitals that is predictable; importance of ensuring financial performance over the long run for rural communities

II. History of health policy experimentation:

- Testing new payment arrangements to control costs of care, improve health care quality, or both
- Demonstrated track record in pursuing broad-based health reform efforts; proven ability of implementing and building on past successes, and leveraging existing resources
- Broad participation with state government partnering with stakeholders to create mechanisms that support system transformation and develop buy-in among key stakeholders (payers, providers, private sector)

III. Development and Implementation

- Vision for transformation including guiding principles, strategies, and initiatives to support comprehensive health reform
- State leadership to establish and maintain clear policy goals and objectives, set expectations for reform, build trust, facilitate dialogue, align payers, and explore mutual gains among stakeholders (consensus-based, when feasible)
- Policy framework and process to develop an implementation and operational strategy to reduce health care cost growth
- Multi-payer and stakeholder participation (voluntary or mandatory)
- Availability of information, data and reporting infrastructure, and providing technical assistance
- Phased-in implementation over a multi-year period

⁸ Backus, E., Costa, M. (April 2018); Holahan, J., Blumberg, L. (2006); Hughes, L. (April 2018); Keane, J., & Anderson, G. (January 2018); Murray, R. (May 2018); Sharfstein, J., Gerovich, S., Moriarty, E., & Chin, D. (August 2017); Weil, A. (2008); Zemel, S., Riley, T. (January 2016).

OREGON POLICY CONSIDERATIONS

The Task Force opted not to recommend adopting Maryland’s historical hospital rate-setting model at this time (1977-2012). Based on a series of presentations from Maryland, national experts, and a set of exercises, members identified potential disadvantages and foreseeable barriers:

- The approach focuses on fee-for-service rather than paying for value and fails to align with Oregon’s payment reform efforts including incentivizing prevention and population health services.
- Hospital care is a shrinking proportion of health care spending, and a hospital-based rate-setting system could potentially incentivize out-migration of care from regulated hospitals to unregulated outpatient providers (non-hospital providers).
- Maryland’s rate-setting system is complex and administratively challenging to implement and maintain over time.
- The model requires a federal Medicare waiver to implement (Maryland is the only state to have received this type of waiver since 1977).

It is important to mention that the Maryland hospital rate-setting model as established and if modeled in Oregon could potentially create significant financial challenges due to existing payer differentials in the state among Medicaid, Medicare, and commercial reimbursement rates. In Maryland, hospitals’ reimbursement rates are close to parity across public and private payers (i.e., held within a 5-10 percent range).

The Task Force did extensively evaluate three alternative policy strategies or models designed to promote cost-containment and payment reform described herein: (1) Pennsylvania’s adoption of global budgets for hospitals, (2) Vermont’s all-payer accountable care organizations, and (3) Massachusetts’ annual expenditure growth target and state benchmark. Members shared their perspectives on the advantages and disadvantages on global budgets for hospitals, all-payer accountable care organizations (ACOs), and a statewide health care cost growth benchmark. Of interest, members identified key environmental factors unique to Oregon that included:

- Coordinated care organization infrastructure
- High penetration of Medicare Advantage Plans
- Patient-centered medical homes
- Rate review process of commercial carriers by the Department of Consumer and Business Services (DCBS)
- Differences among urban and rural markets for payers, providers, and hospitals
- Oregon’s federal 1115 Waiver with the Centers for Medicare and Medicaid Services

For a complete summary of the advantages and disadvantages discussion, please see “Oregon Environment and Key Considerations” matrix ([figure 15](#)). The figure reflects information provided by members during their June 15 meeting, in which members were invited to offer their perspectives and positions on each policy strategy. Information was used to develop a policy framework and straw proposals for the Task Force

to consider in July. It is important to note that the potential advantages and disadvantages outlined below should not be considered an exhaustive list. Rather, the assessment provided by the Task Force provides a framework for understanding how each policy strategy might operate in Oregon and offers a robust list of key considerations including foreseeable barriers and opportunities to leverage existing reform efforts. Each policy strategy was described in Chapter 7.

Global Budgets for Hospitals

Drawing on Maryland's recent move to deploying global budgets for its hospitals, members considered the potential advantages and disadvantages of this model in Oregon as well as Pennsylvania's model that is initially limited to a handful of rural hospitals. The policy goal in this model for Oregon could be transitioning rural hospitals from cost-based reimbursement to a global budget and incentivizing prevention and population health outcomes.

Potential advantages of this model in Oregon are:

- Predictable, stable revenue and cash flow
- Single statewide target
- All providers working towards incentives for efficiencies
- Coordinate solutions to primary care issues

Potential disadvantages of global budgets for hospitals in Oregon are:

- Exclusive to hospitals
- Outliers on spending
- Patient population and attribution challenges
- Hospital's limited ability to control external cost factors (e.g., pharmaceutical costs)
- Potential difficulty obtaining federal approval through waiver(s)

All-payer Accountable Care Organization Pilot

It is important to note that the three policy strategies extensively considered are not mutually exclusive and may complement one another if carefully designed and implemented. For example, members expressed an interest in establishing one or more all-payer ACO pilots in Oregon to expand the coordinated care model to Medicare enrollees. Piloting an all-payer ACO model will allow Oregon to further align payment and incentives across payers incrementally and learn from other states that are currently in the early stages of implementation.

Potential advantages of this model in Oregon are:

- Needs single payment model
- Allows for local payment models based on providers and geographic needs
- Aligns care delivery and quality across payers and provider types regardless of revenue source
- Offers flexibility in payment design
- Spreads risk across population groups
- Offers a single approach to addressing cost containment and payment reform

Members also identified potential disadvantages to an all-payer ACO model in Oregon:

- Scalability and difficulty transitioning from fee-for-service to alternative payment model(s)
- Widespread buy-in with payers and carriers
- Unclear if approach will result in cost containment
- Models in other states early in implementation; no long-term results available
- Unknown whether model will translate to lower costs for consumers
- Potential difficulty obtaining federal approval through waivers

Annual Growth Target and Statewide Benchmark

The third policy strategy considered was based on Massachusetts' statewide benchmark. The goal of establishing a statewide growth target is to apply a cost containment strategy across all payers and providers. This approach also offers a fixed, stable, and predictable rate of health care expenditures, allows market flexibility, and promotes innovation among organizations to meet the benchmark.

As with the two previous policy strategies, members identified potential advantages for this approach in Oregon:

- Feasibility
- Transparency
- Leverage infrastructure to support alternative payment model (APM)
- Demonstrated effectiveness based on Oregon's 2012-17 experience in Medicaid
- Offers a single point of accountability
- Recognizes multiple factors that affect cost growth
- Offers additional tools, data, and reporting regardless of provider type or payer source

Potential disadvantages of establishing a statewide growth benchmark in Oregon include:

- Unclear whether model will address health disparities
- Level of enforceability
- Unclear if model will impact prescription drug costs
- Model locks in existing price and payer variation

Based on the informed evaluation of each model, the Task Force identified four potential policy strategies as well as a set of potential advantages and disadvantages shared *across* all three strategies. The assessment put forth by the Task Force is outlined below.

Promote Cost Containment

- Gradual transition from fee-for-service to capitation via accountable care organization (ACO model)
- Reduce cost growth, address ability to contain costs and establish targets for total cost of care
- Use of specified goals, spending targets, and trend factors
- Inpatient and outpatient focus among hospitals and primary care providers
- Use of benchmark applied to all types of health care expenditures and provider types

Support Payment Reform

- Align prospective payments across payers through ACOs
- Flexibility to use alternative payment models (APMs) and targets including supporting non-traditional health services

Address Price Variation Among Payers and Providers

- Align payment models across public and private payers
- Reduce price variations among provider types, services, and locations

Offer Multi-payer Approach (public and private)

- Comprehensive, all-payer is more effective
- Accelerate the adoption and spread of APMs across payers

Potential Advantages in Oregon

- Create a fixed, stable, predictable rate of spending
- Build on Oregon's successful 3.4% rate of growth in Medicaid and the coordinated care model
- Flexible and market-oriented solution
- Mechanism(s) to review and approve hospital budgets
- Promote accountability through reporting, transparency, and public hearings

Potential Disadvantages in Oregon

- Applicability to Oregon's health care environment
- Administration complexities
- Limited enforcement
- Incomplete results

The Task Force engaged in a prioritizing exercise focused on three policy strategies: global budgets for hospitals, all-payer accountable care organizations (ACOs), and a statewide health care cost growth benchmark (see [figure 15](#)). The results from the exercise were used to develop a policy framework which was distributed in advance of the July meeting. Based on the guidance, robust discussion, member feedback in person and in writing, and the assessment summarized above, members opted to move forward with a model similar to Massachusetts' cost containment approach adapted for Oregon's health care environment.

Figure 15: Other States' Approaches to Cost Containment and Payment Reform Policy Strategies: Oregon Environment and Key Considerations

Policy Strategies	Oregon Environment and Key Considerations*			
	Potential Advantages	Potential Disadvantages	Foreseeable Barriers	Leverage Existing Reform Efforts
Global Budgets for Hospitals <ul style="list-style-type: none"> Transition rural hospitals from cost-based reimbursement to global budgets Incentivize prevention and population health <p>G:3, Y:4, R:2, B:2</p>	<ul style="list-style-type: none"> Predictable, stable revenue and cash flow Single statewide target All providers working towards incentives for efficiencies Coordinate solutions to primary care issues 	<ul style="list-style-type: none"> Exclusive to hospitals Examine outliers on spending Patient population and attribution challenges Ability to influence prices outside hospital control Potential difficulty obtaining federal approval through waivers 	<ul style="list-style-type: none"> Complexity establishing and maintaining global budgets Measure spending across hospital types (DRG, Type A, B, & C hospitals), services, and adjusting for patient mix Adequate operational infrastructure Federal waiver authority Measuring quality Carrier relationships and payer mix 	<ul style="list-style-type: none"> CCO infrastructure Medicaid waiver Total Cost of Care work led by HealthInsight
Accountable Care Organizations <ul style="list-style-type: none"> Expand CCO model to Medicare enrollees (traditional/Medicare Advantage) Align payment and incentives across payers <p>G:12, B:8</p>	<ul style="list-style-type: none"> Single payment model Allows for local payment models based on providers and geographic needs Aligns care delivery and quality across payers and provider types regardless of revenue source Offers flexibility in payment design Spreads risk across population groups Offers a single approach to addressing cost containment and payment reform 	<ul style="list-style-type: none"> Scalability and difficulty transitioning from fee-for-service to alternative payment model(s) Widespread buy-in with payers and carriers Unclear if the approach will result in cost containment Models in other states early in implementation; no long-term results available Unknown whether model will translate to lower costs for consumers Potential difficulty obtaining federal approval through waivers 	<ul style="list-style-type: none"> Administrative consistency infrastructure waiver carrier dynamics 	<ul style="list-style-type: none"> CCO and Medicare Advantage
Annual Growth Target & State Benchmark <ul style="list-style-type: none"> Establish single target growth rate for all payers and providers Fixed, stable, and predictable rate of spending Allow market flexibility to meet benchmark(s) Create penalties and/or incentives for outliers <p>G:21, B:1</p>	<ul style="list-style-type: none"> Feasibility Transparency Leverage infrastructure to support APM Demonstrated effectiveness based on Oregon's 2012-17 experience in Medicaid Offers a single point of accountability Recognizes multiple factors that affect cost growth Offers additional tools, data, and reporting regardless of provider type or payer source 	<ul style="list-style-type: none"> Unclear whether model will address health disparities Level of enforceability Unclear if model will impact prescription drug costs Lock-in existing price and payer variation 	<ul style="list-style-type: none"> Developing infrastructure Identifying statewide growth target Enforcement mechanism Applying benchmark to commercial and self-funded plans Ability to address and enforce penalties among outliers 	<ul style="list-style-type: none"> Existing growth rates for Medicaid, PEBB, & OEBC (i.e., 3.4 percent)
Hybrid/Other <p>G:6, B:3</p>	<ul style="list-style-type: none"> Community specific design More tools and data 			

*Dot Legend

- Green ● Yes, this concept supports Oregon's goals
- Yellow ● I am neutral on this concept
- Red ● No, this concept does not support Oregon's goals
- Blue ● I need more information before I can form an opinion

CHAPTER 9

RECOMMENDATION: ESTABLISH A STATEWIDE GROWTH BENCHMARK

In response to the legislative direction in SB 419 (2017), the Guiding Principles and Objectives as reflected in the adopted Charter ([adopted Jan. 19, 2018](#)), and the policy priorities as identified, the Task Force unanimously adopted the recommendations that follow. These are in response to the tasks delineated in SB 419.

Oregon is in a unique position to leverage existing health care cost containment efforts and payment model(s) that share risk and accountability among payers and providers, with an emphasis on all-payer approaches that align payment models across public and private payers to reduce price variations among provider types, services, and locations. Collectively, these efforts will help accelerate Oregon's health care transformation efforts and support the Triple Aim by further moving from a fee-for-service system that pays for quantity to a value-based payment system that incentivizes and promotes improved quality and population health outcomes across all payers.

A foundational underpinning for those efforts is ensuring the long-term affordability and financial sustainability of health care system in Oregon. To that end, the Joint Task Force on Health Care Cost Review recommends enhancing the transparency of the state's health care system, identifying and addressing health costs and prices through a public reporting process, and establishing a statewide target for the annual rate of growth to control total health care expenditures in Oregon.

GOAL STATEMENT

To create an Oregon plan to control total health care expenditures across *all payers and providers* by establishing a health care spending benchmark—a statewide target for the annual rate of growth of total health care expenditures.

BUILDING BLOCKS FOR HEALTH CARE COST GROWTH BENCHMARK

- Establish a single statewide benchmark for health care spending that is fixed, stable, predictable, and economically sustainable.
- Develop and adopt a benchmark methodology to measure total cost of care across health care at the state level, and as practical, account for variations of patient mix, and geographic regions and workforce.
- Ensure calculation of total health care expenditures encompass spending on all health care services across the state for all populations.
- Identify individual health care providers and payers who shall publicly report, and are to be held accountable for staying at or below the benchmark.
- Determine oversight entity responsible for maintaining and enforcing the benchmark; identify outlier costs, price variation, waste or inefficiency, and cost drivers that contribute to growth; and report annually to the Legislative Assembly.
- Support market-oriented approach by enhancing public reporting, transparency, and collective accountability for spending for all providers and payers.
- Align reporting and use of quality measures across payers and providers as foundational to the improvement and accountability structure for the benchmark.

The building blocks and policy framework, staged incrementally, are designed to control the annual growth of health care expenditures and enhance Oregon’s ability to achieve an affordable and financially sustainable health care system. Furthermore, the proposed implementation timeline seeks to balance a sense of urgency with feasibility.

POLICY BLUEPRINT AND IMPLEMENTATION FRAMEWORK – HOW TO GET THERE

Phase 1 – 2018: Task Force Adopts and Recommends Policy Framework and Blueprint

The Joint Task Force on Health Care Cost Review submits a report with recommendations to the Legislative Assembly that includes:

- building blocks and policy framework to advance the creation of a statewide spending benchmark in Oregon by 2020; and
- a timeline, blueprint outline for 2020-2021, and suggested entities that may potentially be involved in developing, implementing, and operationalizing the statewide benchmark.

Phase 2 – 2019: Legislation authorizing and directing an implementation advisory group to establish the state benchmark, the methodology, and create a fee-based revenue model

Convene an implementation advisory group (see proposed list on pg. 46) to advise in the design and operationalization of the health care spending benchmark that reflects a predictable and sustainable annual rate of growth for health care expenditures. The advisory body is responsible for, but not limited to, the following tasks referred to as the “blueprint.” Executive agencies are directed to assist

the implementation group and are responsible for identifying external resources and expertise needed to advise and complete the blueprint (see proposed model, figure 17, pg. 45).

1. **Governance Structure:** Determine the governance structure, authority, composition, and infrastructure to support refinement of design and implementation of benchmark. Implementation group shall evaluate whether the operational and accountability functions should be housed in an existing agency and/or governing body, necessitate creation of a new entity, be contracted to a private entity, or be supported by a private-public partnership (hybrid approach). The assessment shall include an evaluation of the advantages and disadvantages of different governance models particularly using an existing governing board such as the Oregon Health Policy Board. The advisory group shall recommend a governance model to be responsible for annual monitoring and accountability of the health care cost growth benchmark starting in 2022.
2. **Develop Benchmark Methodology:** Evaluate potential economic indicators by which a statewide health care cost growth benchmark could be evaluated (e.g., wage growth, state gross state, e.g., an inflation index such as the Consumer Price Index) and recommend a methodology for establishing an economically sustainable and appropriate growth rate target. Assess and propose methodology that takes into consideration Oregon's existing price and expenditure variation, both warranted and unwarranted, across health care provider settings.
3. **Identify Data, Infrastructure, and Support Needs:** Evaluate existing data sources and perform a gap analysis to determine what additional data is needed to establish a system that measures total health care expenditures, supports reporting on and accountability to a statewide benchmark, and provides understanding of both systemic and specific issues and trends underlying cost growth. Determine technical assistance and support needs to help ensure organizations will be successful. Evaluate opportunities to leverage existing financial and state resources, and if necessary, propose alternative funding models including a fee-based approach similar to Massachusetts.
4. **Reporting, Transparency, Accountability, and Enforcement:** Evaluate and recommend an approach for reporting total costs of care, quality, efficiency tools, and enforcement mechanisms. Create a reporting system to identify unwarranted factors contributing to price variation or growth. Determine reporting requirements for individual providers and payer types, periodicity of reporting, a mechanism for public reporting, and the process required to ensure accountability including enforcement actions for lack of reporting or failing to meet the benchmark target. Accountability initially involves a performance improvement plan and may progress to enforcement based on repeated violations (i.e., inability to meet benchmark target).
5. **Leverage Existing Infrastructure:** Evaluate and recommend how the statewide benchmark will be further used by state programs including Medicaid/CCOs, commercial market rate review, Marketplace, as well as PEBB and OEGB contracts.
6. **Timeline:** Establish an implementation timeline, phases of implementation, and comprehensive implementation plan for approval by the Legislative Assembly. This may include establishing a statewide growth benchmark target and reporting requirements in 2019, with a phased-in reporting period of 12-24 months for provider organizations (2020-2021), with annual hearings, enforcement, and potential penalties taking effect starting 2022.

Phase 3 – 2020-2021 - Report to Legislative Assembly and Implementation

1. Based on recommendations from advisory group, the legislatively authorized entity from 2019 legislation transitions to implementation phase through rulemaking authority.
2. Establish long-term governing structure and provide technical assistance to reporting entities.
3. Establish annual reporting to the Legislative Assembly and public on total health care expenditures and quality outcomes by health care setting.
4. Develop and submit annual report with policy and strategy recommendations to the Legislative Assembly that support efforts to achieve the health care cost growth benchmark.

Phase 4 – 2022 & Beyond - Accountability and Enforcement

1. Assess market responses to statewide benchmark(s) and hold inaugural, annual, formal hearings on total state expenditures and cost growth in Oregon.
2. Determine appropriate response to entities that do not achieve benchmark(s).
3. Evaluate policy and strategy recommendations; support adoption of additional strategies for health care market segments aimed at achieving a sustainable rate of growth.
4. Report to the Legislative Assembly on progress and future recommended changes to the program.

Figure 17. Proposed Statewide Benchmark Model

Key Design Features	
Governance Model/Structure	<ul style="list-style-type: none"> • New or existing governance body with modifications to membership composition
Develop Benchmark Methodology and Total Cost of Care	<ul style="list-style-type: none"> • Benchmark: review economic indicators and recommend appropriate index (e.g., State Gross Domestic Product, Consumer Price Index, Regional Adjustments) • Total Cost of Care: determine populations, services with limited to no carveouts, and types of spending (claims, non-claims-based spending)
Scope of Benchmark	<ul style="list-style-type: none"> • All payers and provider organizations (commercial, Medicare, Medicaid, self-funded plans, insurers, health systems/hospitals, provider organizations)
Data and Infrastructure	<ul style="list-style-type: none"> • Existing infrastructure (e.g., All-Payer Claims Database); assess additional data collection and reporting needs; staffing/resource requirements
Reporting and Transparency	<ul style="list-style-type: none"> • Comprehensive public reporting and full disclosure • Disclosure of expenditure and price data • Identify systemic issues contributing to cost growth
Authority and Enforcement	<ul style="list-style-type: none"> • Annual public hearings • Enforcement - formal review and performance improvement plan • Establish mechanisms for non-compliance
Funding	<ul style="list-style-type: none"> • Develop funding model to support staffing, data, and analytic infrastructure. Evaluate opportunities to leverage existing resources – if necessary, propose alternative funding models, including a fee-based approach
Timeframe	<ul style="list-style-type: none"> • Establish growth target by 2020 • Phased-in accountability starting 2022 • Automatic adjustment of benchmark five years after establishment unless governing body acts beforehand

IMPLEMENTATION ADVISORY GROUP

Stakeholders to consider as representatives for the Implementation Advisory Group to advise the Legislative Assembly regarding the blueprint development:

- Director of the Oregon Health Authority
- Member(s) of the Oregon Health Policy Board
- Director of the Department of Consumer and Business Services
- Member(s) of the Marketplace Advisory Committee
- Chief Financial Officer, State of Oregon (State Economic Advisors)
- Member(s) of the Oregon Health Leadership Council
- Member(s) representing a health care system or hospital
- Member(s) representing a rural hospital
- Consumer representatives
- Member(s) with expertise in health care financing, administration, and payment
- Member of the business community that purchases health insurance
- Licensed health care professionals' representative of the diversity of provider types
- Member(s) of the insurance industry-including a broker
- Health economist

KEY TERMINOLOGY

Health care costs ([NIH](#)): the expenses incurred by an organization in providing care. The costs attributed to a particular patient care episode include the direct costs plus an appropriate proportion of the overhead for administration, personnel, building maintenance, equipment, etc.

Health care cost growth benchmark (MA's definition): The projected annual percentage change in Total Health Care Expenditure (THCE) measure, as established by an independent governing body. The benchmark is tied to an economic indicator that reflects the growth in the state's economy.

Health expenditures ([NIH](#)): The amounts spent by individuals, groups, private or public organizations for total health care and/or its various components. These amounts may or may not be equivalent to the actual costs and may or may not be shared among the patient, insurers, and/or employers.

National or state health expenditures: This measure estimates the amount spent for all health services and supplies and health-related research and construction activities consumed in a defined geographic location during the calendar year. Detailed estimates include source of expenditures (for example, out-of-pocket payments, private health insurance, and government programs), and by type of expenditures (e.g., hospital care, physician services, and drugs), and are in current dollars for the year of report.

Total cost of care (TCOC) ([HealthPartners](#)): is a name for a method of measuring health care affordability and measures all care (professional, inpatient, outpatient, pharmacy, ancillary), is indicative of price and resource use drivers at every level, uses Johns Hopkins Adjusted Clinical Groups (ACGs) for effective comparisons and benchmarking, displayed as an index to protect competitive information while being transparent with relative performance and price for procedures and services, and tested and reviewed over a three-year period for reliability and validity.

Total health care expenditures (THCE): A measure of total spending for health care defined as the annual per capita sum of all health care expenditures in Oregon from public and private sources, including: (i) all categories of medical expenses and all non-claims-related payments to providers; (ii) all patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of private health insurance, or as otherwise defined in legislation.

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APPENDIX A: LIST OF PRESENTERS

DELAWARE

Steven Costantino, Director of Health Care Reform and Financing, Delaware Health and Social Services

MARYLAND

Gerald Anderson, Professor, Johns Hopkins Bloomberg School of Public Health

Jack Keane, Commissioner, Maryland Health Services Cost Review Commission

Aaron Larrimore, Chief of Innovation and Delivery System Reform, Maryland Department of Health and Mental Hygiene

Robert Murray, Executive Director, Maryland Health Services Cost Review Commission

Allan Pack, Principal Deputy Director, Maryland Health Services Cost Review Commission

Chris Peterson, Principal Deputy Director, Maryland Health Services Cost Review Commission

MASSACHUSETTS

Michael Cannella, Legislative Director, Office of Sen. Welch

David Seltz, Executive Director, Massachusetts Health Policy Commission

Sen. James Welch, Hampden District, Massachusetts; Chair, Joint Committee on Health Care Cost Containment and Reform

OREGON

Rick Blackwell, Policy Manager, Division of Financial Regulation, Department of Consumer and Business Services

Myliia Christensen, Chief Operating Officer, HealthInsight

Robert Gluckman, Chief Medical Officer, Providence Health Plans

John McConnell, health economist, Center for Health Systems Effectiveness, Oregon Health and Science University

Steven Ranzoni, Hospital Policy Advisor, Office of Health Analytics, Health Policy and Analytics Division, Oregon Health Authority

Meredith Roberts Tomasi, Associate Executive Director, HealthInsight

Stacy Schubert, Manager, Research and Data, Office of Health Analytics, Health Policy and Analytics Division, Oregon Health Authority

Michael Whitbeck, Medical Group Administrator, NW Primary Care Group

PENNSYLVANIA

Lauren Hughes, Deputy Secretary of Health Innovation, Pennsylvania Department of Health

VERMONT

Ena Backus, Chief of Health Policy, State of Vermont Green Mountain Care Board

Michael Costa, Deputy Commissioner, Health Services and Managed Care, Department of Vermont Health Access

APPENDIX B: TASK FORCE PRESENTATIONS AND MATERIALS

Meeting Date	Materials
Nov. 16, 2017	Maryland model article, Health Affairs, 2009
Dec. 15, 2017	Hospital Rate Setting Revisited, Urban Institute, 2015 Maryland Health Services Cost Review Commission, Robert Murray presentation
Jan. 19, 2018	Maryland Health Services Cost Review Commission, Allan Pack and Chris Peterson presentation Maryland Department of Health and Mental Hygiene, Aaron Larrimore presentation Evaluation of Maryland All-Payer Model Report, Center for Medicare and Medicaid Innovation, 2017 Managed Care in Maryland Summary, Medicaid.gov, 2014 Maryland All-Payer Model Achievements, Challenges, and Next Steps, Health Affairs, 2017
March 9, 2018	Health Care Spending and Pricing Overview - K. John McConnell presentation Oregon Acute Hospitals: Financials, Reporting, and Trends - Steven Ranzoni presentation Oregon Acute Hospitals, Financials Reporting, and Trends - Steven Ranzoni handout Hospital Reporting Program Resources, Oregon Health Authority Maryland Model Summary, Maryland Health Services Cost Review Commission Oregon Acute Care Hospitals Financial and Utilization Trends, Oregon Health Authority Oregon Hospital Payment Report, Oregon Health Authority, 2015

Meeting Date	Materials
Apr. 20, 2018	Massachusetts Health Policy Commission presentation Massachusetts Health Policy Commission report (2017 Annual Health Care Cost Trends) National Academy for State Health Policy issue brief (Global Budgeting Initiatives in MD, MA, & VT) Oregon Health Authority, Office of Health Analytics, Oregon Hospital Classifications handout Pennsylvania Rural Health Model Presentation U.S. Center for Medicare & Medicaid Innovation Pennsylvania Rural Health Model backgrounder Vermont presentation, Ena Backus and Michael Costa
May 11, 2018	Clinic Comparison sample report, HealthInsight Multi-stakeholder Approach to Addressing Total Cost of Care presentation, HealthInsight M. Christensen, B. Gluckman, MD, M. Roberts Tomasi, M. Whitbeck Healthcare Affordability, Untangling Cost Drivers report, Network for Regional Healthcare Improvement Medicare Advantage fact sheet, 2017 State Comparison backgrounder
June 15, 2018	Massachusetts Health Policy Commission, ACO Policy Brief, April 2018 Implementing Hospital Global Budgets, Opportunities and Challenges Summary, May 2018 Toward Hospital Global Budgeting: State Considerations brief, Robert Murray, May 2018
July 13, 2018	Massachusetts Health Policy Commission, David Seltz presentation
Aug. 17, 2018	Draft final report with recommendations
Sept. 6, 2018	Final report draft with track changes

APPENDIX C: ADDITIONAL RESOURCES

MASSACHUSETTS

- Health Policy Commission website
 - [2017 Annual Cost Trends Report](#) (published March 2018)
- Anthony, B. (September 2017). [Beyond Obamacare: Lessons from Massachusetts, A Brief History of Health Care Reform in Massachusetts](#). Harvard Kennedy School.
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DELAWARE

- Delaware Health Care Commission. Health Care Spending Benchmark [website](#)
- Delaware Health and Social Services (December 2017). [Report to the Delaware General Assembly on Establishing a Health Care Benchmark](#).
- Health Care Benchmark Summits (2017) [website](#).
- Health Care Advisory Group. [Final Advisory Group Summary Report](#), June 25, 2018.