

**Oregon Educators Benefit Board  
Quality Workgroup  
Final Disease/Health Management and  
Quality Recommendations**

**1. Introduction**

The OEBB Board has indicated in its vision and guiding principles that it wishes to include a focus on quality and employee health and wellness in its selection of health plans. The Board specifically identified the need for measurable programs and services that are evidence-based, hold providers accountable for health outcomes, and provide consumers with the information and resources needed to make knowledgeable health decisions.

SB 426 requires that the plans/plan designs selected by OEBB meet some specific requirements in terms of comparability of plan designs and costs to those experienced under the current environment. This means that, although OEBB can emphasize high-quality components in its initial selection criteria, it must also be closely attuned to potential upfront costs of including such components, especially if they are not already in place within current health plans.

Through its initial plan design and selection and contracting processes, OEBB can set the stage by establishing expectations that health plans will increasingly become more oriented to health management, quality and data issues in their management of services with their providers and their members. OEBB can do that and maintain comparability by focusing on key processes, system components and quality measurements in its development of plan designs and initial scoring and selection processes, but also by establishing at the front-end certain expectations for those who eventually become contractors.

The Quality Workgroup has developed a set of recommendations on quality and disease/health management components or requirements that should be part of the selection process in 2008 and potentially the renewal/selection process in 2009. The Quality Workgroup has also outlined potential data collection and reporting needs that should be included in medical RFPs in 2008 and subsequent years.

## **2. Plan designs that promote member health and wellness**

**a) Plan Design Elements** – During its plan design process, OEBB should consider the availability and member cost sharing for the following programs and services as a means to improve overall health and wellness. Bidders will be asked to separately bid on the following elements so that the cost of these elements can be assessed against standard (“comparable”) plan designs.

- 100% coverage (no copay or out-of-pocket costs) of U.S. Preventive Services Task Force recommended periodic preventive screenings (NOT annual physical exams across the board).
- 100% coverage (no copay or out-of-pocket costs) of immunizations recommended by the Centers for Disease Control’s Immunization Practices Advisory Committee and Oregon state law.
- Prescription drug plan possibilities:
  - Three-tiered prescription drug benefit divided between generic, preferred and nonpreferred medications.
  - Formularies for preferred medications that include a minimum of one drug from every therapeutic class.
  - Annual maximum out of pockets for individual and family.
- Other plan considerations:
  - Lower member cost-sharing for preventive medications and medications used in chronic disease management,
  - Possible coverage designs for specialty medications,
  - Lower member cost-sharing for diabetic supplies,
  - Coverage of select tobacco cessation medications along with home-delivered Over-the-Counter (OTC) nicotine replacement patches/gum/lozenges,
  - OEBB will evaluate the benefits/costs of participating in the Oregon Prescription Drug Program.

## **3. Health plans systems and processes related to quality improvement**

**a) Bidding Requirements** – Specific quality improvement systems or programs that bidders must agree to implement or participate in to bid on any of the OEBB’s health plan RFPs.

- **Participation in eValue8 Request for Information (RFI)** – eValue8 is a nationally-recognized tool developed by the National Business Coalition on Health that provides purchasers with the ability to evaluate the performance of health plans on a wide variety of quality indicators. Almost all of the Oregon-based health plans participated in eValue8 in 2007. Requiring participation in the eValue8 RFI would provide OEGB with a baseline measurement on participating health plans processes and systems related to a large number of quality indicators. Subsequent eValue8 assessments can then be used in bringing about quality improvements at participating health plans through the contract renewal process.

**b) Assessment of Health Plan Systems and Processes** – Bidders will be asked to provide data on their ability and projected costs for providing or implementing the following quality-improvement programs and services. This information along with provided data on past experience and effectiveness will be used in the selection process.

- **Quality**

- Consumer Information and Resources.

- Online provider quality and cost rating tools by procedure

- Integration and Technology

- Active promotion of electronic medical records.
    - Provision of standard Personal Health Records for beneficiaries, with feeds from member and various data sources.
    - Provide incentives for interoperable Health IT.
    - Behavioral health networks that include 24/7 support to member and primary care
    - Participating in community collaborative efforts to create “medical homes” that allow patients to receive personalized care and resources that are coordinated and managed by a single practitioner or team.

- Measurement and Reporting

- Actively encourage contracted hospitals participation and reporting to the Leapfrog Initiative.
    - Provide support to community collaborative efforts on primary care measurement and reporting (Oregon has a broad-based effort involving most health plans that will serve as a basis for more valid physician performance

- reporting and improvement than if it is only done on an individual plan basis).
  - Required reporting on selected (OEBC-defined) Healthcare Effectiveness Data and Information Set (HEDIS) measures.
  - Study geographic variations in care and provide related beneficiary and provider education.
- Programs and Services
- Centers of Excellence for targeted procedures (e.g. major surgeries, transplants)
  - Use of value-based plan designs (e.g. Rx, pay-for-performance).
- Utilization Management
- Mandatory “notification” of non-emergency hospital admissions (Stronger alternative: Mandatory “pre-admission review”) with financial penalty.
  - Length-of-stay management (concurrent review, including pro-active discharge planning at admission).
  - Large case management.
  - Coordination with short-term disability, EAPs, health care decision-support.
  - Targeted retrospective review of non-preauthorized admissions to improve quality in the future.
- Pharmaceutical Benefit Management
- Programs, Services and Utilization
- Program to increase generic drug utilization by prescribers and providers.
  - Maintenance of an evidence-based formulary, including a detailed process regarding formulary creation and management.
  - Management of a step therapy program.
  - Quantifiable and documented prescription management prior authorization process.
  - Prescriber engagement and feedback program.
  - Medication adherence program.
- Patient Safety
- Promotion and incentives for e-prescribing use and systems.
  - Review of patients’ adverse events.
  - Programs/systems to reduce dispensing errors.

#### **4. Expectations of OEGB contract recipients**

Specific actions or items that OEGB requires a health plan contract recipient to provide or undertake once a contract with OEGB has been signed.

- Reporting of selected (OEGB-defined) HEDIS measures by health plans.
- Providing support to community collaborative efforts to improve primary care measurement and reporting (Oregon has a broad-based effort involving most health plans that will serve as a basis for more valid physician performance reporting and improvement than if it is only done on an individual plan basis).
- Participating in community collaborative efforts to create “medical homes” that allow patients to receive personalized care and resources that are coordinated and managed by a single practitioner or team.
- Continued participation in eValue8.
- Require detailed performance guarantees in regards to the pharmacy benefit that may include: speed to answer, abandon rates, member satisfaction, OEGB satisfaction, turn around time at home delivery, accuracy at home delivery, key indicator milestones or benchmarks.
- Complete transparency in regards to all prescription pricing components.

#### **5. Programs and services that support member health and disease management**

The recommendations below are based on best practices among large health plans in the United States, which are derived from published medical evidence and from expert opinions and experiences. The 10/1/2008 recommendations are aligned, as best we know at this moment in time, with prevailing levels of benefits among Oregon health plans for school district employees. Vendors will be asked to provide data on their ability and projected costs for providing or implementing the following programs and services. This information along with provided data on past experience and effectiveness will be used in the selection process. Additional elements are to be considered for potential inclusion on 10/1/2009.

##### ➤ Recommendations for 10/1/2008

##### - Health management

- Web portal
- Online lifestyle change programs
- Online health search engine
- Online health information
- Tobacco cessation program (online and telephone), including home-delivered nicotine replacement therapy medications (patch, gum, lozenge).

- Disease Management Program including high risk maternity

- Predictive modeling by the carrier or vendor.
- Effective outreach and participant engagement.
- Coaching by RNs (online and telephone).
- Other online and mailed educational programs, materials, tools and clinical monitoring
- Coordination with short-term disability program, EAPs, utilization management, health care decision-support

- Health Care Decision-Support

- RN coaching for preference-sensitive conditions (online and telephone).
- RN coaching for triage of minor illnesses & injuries (online and telephone).
- Online tools.
- Home-delivered self-care book to each family.

- Recommendations for 10/1/2009 – The programs and services listed below are recommended additions to be potentially used in the assessing and scoring for contract renewal/selection on 10/1/2009.

- Health Management

- Online and paper Health Risk Appraisals
- Onsite biometric screenings
- Lifestyle behavior change coaching (e.g. exercise, weight management, stress management, nutrition).
- Personalization of online health information/tools and telephone services

- Disease Management

- Expanded disease management program (to be verified by Avoidable Claims Analysis) that may include depression, asthma, Chronic Obstructive Pulmonary Disease, and other conditions for improvements in quality and cost management.

- Recommendation for Disease/Health Management Request for Proposals

The health and disease management marketplace has been in a state of change and development for the past 5 years. There have been many mergers and acquisitions, as well as health insurance companies and carve-out specialty vendors are all ardently pursuing the ability to provide comprehensive, end-to-end, integrated

health and disease management services. The HQDW and Watson Wyatt believe that no health insurance company, nor any single carve-out vendor, has best-practice services in all areas.

The HQDW recommends that the OEGB request for proposal for health and disease management services be available to both health insurance companies and specialty carve-out vendors. The proposals will be evaluated on a number of factors, including program quality, outcomes, costs and member satisfaction. OEGB can then select the vendor(s) best able to administer an optimal health and/or disease management program at the lowest cost.

#### **6. Data collection and reporting**

The Quality Workgroup recommends that OEGB include in its medical RFPs requirements or an assessment of vendors' capabilities related to data collection and reporting on a number of areas including claims data, financial management, utilization, health management and quality of care. Further details on requirements and assessment criteria will be included in the individual RFPs. In 2009, OEGB should expand its data collection and reporting requirements to include disease and health management data on program participation, health risk levels, and disease burden. By 2010, it's expected that OEGB will have a robust data collection and analysis system that supports financial management, cost and use analysis, identification of new opportunities, program monitoring, proof of impact, and discovery of best practices.