Governance Technical Advisory Group

Task Force on Universal Health Care

May 27, 2021

Summary of Proposals from Governance TAG

Values

The following may be used to provide direction on the mission, values, and goals of the Single Payer:

1. The Single Payer is dedicated to improving the health status of individuals, families, and communities.
2. Health care, as a fundamental element of a just society, is to be secured for all individuals on an equitable basis by public means.
3. Access to a distribution of health care resources and services according to individuals' needs and locations within the state should be available. Race, color, national origin, age, disability, wealth, income, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and related medical conditions, including termination of pregnancy, may not create any barriers to health care nor disparities in health outcomes.
4. The components and governance of the system must be accountable and transparent to the public.
5. The Single Payer will invest in local communities and engage community members and health care providers in improving the health of the communities and addressing regional, cultural, socioeconomic, and racial disparities in health care.
6. The Single Payer and Regional Entities must prioritize their obligations to individuals, families and communities of Oregon with the sound stewardship of taxpayer dollars

Roles

The Single Payer entity will have the following roles:

- **Apply the reserve powers unique to the Single Payer for financial management and stewardship**
  This includes:
  - Establishing all aspect of global budget which includes:
    - Designing payment structures and rate setting to the delivery systems
    - Ensure that payments are adjusted for reduction in administrative costs
  - Leading quality improvement and cost control efforts
    - Development of performance improvements broadly
    - Administrative simplification
    - Set utilization control policies

        - Organization of large capital investments to ensure improved access to care and health equity
        - Explore multi-state purchasing approaches
        - Prevent fraud, waste, and abuse
    - Supporting regional economies

- **Oversee program administration**
  Ensures quality operations, including but not limited to:
    - Claims administration
    - Financial management
    - Data collection, analysis, and evaluation
    - Quality assurance and improvement, patient safety, and patients' experience
    - Customer service, including complaints, grievances, member education and communication

- **Develop and implement program policy**
  This includes:
    - Determining coverage, including monitoring and addressing changes to health care (e.g. technologies, therapies, pharmaceuticals)
    - Strategic planning for long-term system success

- **Support delivery system reform/improvement**
  This includes development of value-based payment mechanisms, tracking spending and utilization, data analysis, and reporting

- **Achieve health equity to improve access, quality of care**
  This includes goal setting, data analysis and reporting (utilization, quality, outcomes) and obtaining reliable information about race, ethnicity, and other aspects at the time of participants' registration.

- **Support workforce development**
  This includes:
    - Identification of workforce needs and capacity
    - Work with stakeholders on approaches to address needed funding and training needs
    - Support workforce recruitment, retention and development, prioritizing recruitment of clinicians of color

- **Develops and maintains the population health-based information system**
  The information system will:
    - Include clinical, financial, utilization, quality, and other needed information to evaluate systemwide performance and quality
    - Ensure transparency with access to the data for the population at large

Single Payer role in the context of tribal sovereignty

- As a government entity, the Single Payer should maintain a government-to-government relationship with the tribes
- At the level of an individual, tribal members would have the ability to seek care within the Indian Health Service tribal systems, as well as be eligible for the Single Payer
- Further discussions with tribal leaders will be needed in the development of the Single Payer regarding the relationship of the tribal health system and the Single Payer

Structure

The Single Payer should be a public entity designed with features to ensure the following:

- Reporting responsibility to the Oregon Legislative Assemblyt and Governor
- Ability to accept all types of funds (e.g. federal, state, donations)
- The Single Payer revenue is not subject to Oregon's kicker tax rebate
- Authority for development and maintenance of prudent financial reserves to ensure solvency. These reserves can only be appropriated by the Single Payer.

Board

- The Single Payer board membership will:
    - Require Governor appointment and Senate confirmation
    - Represent a balance of expertise in health care and have an authentic community voice
    - Demonstrate no conflicts of interest at time of appointment, during their terms, and for a significant period after leaving the Board.
    - Receive remuneration for their time
- The Board will have both community and regional delivery system advisory committees
- Further discussion will be needed to determine the number of board members and the terms of membership
- The Board will recruit and hire key staff for the Single Payer. Single Payer staff will not be politically appointed.

Summary of Proposals from Governance TAG Meetings on April 15 and April 26, 2021

Regional Entities: Roles

Regional Entities will have the following roles:

- Advise the Single Payer related to management/implementation/coordination of care for the region which could include:
    - Advise on budget from the Single Payer entity to region's providers
    - Advise on contract and methods for reimbursing providers
- Manage a budget for health improvement, medical capital and infrastructure projects, and ongoing stakeholder engagement.
- Ongoing community and stakeholder convening and regional planning processes to assess and prioritize regional health and financial needs, focusing on prevention, chronic conditions and equity
- Local government's work with the Single Payer will be through the Regional Entity(s)
- Assist and advise providers on the creation/improvement of delivery systems, foster innovation, and provide input on how incentives should be targeted and measured
- Promote collaboration across the regional delivery system and other regions

Regional Entities: Structure

- There will be one Regional Entity allowed per region
- The Regional Entities will be as transparent and publicly accountable as the Single Payer
- A board of Regional Entities recommends the budgets and contracts for each region

- The number of regions and boundaries will be determined by the single payer. Novel approaches should be considered such as the regional equity coalition design or other alignments with community or regional structures.

Regional Entity Relationship with the Single Payer Includes:

- The Single Payer determines criteria for Regional Entities
    - The Single Payer will consider existing stakeholder engagement structures like Regional Health Equity Coalitions in determining regions
- Single payer will ensure that the Regional Entity is regularly convening and engaging stakeholders in the region
- The Single payer will ensure that the Regional Entity conducts ongoing stakeholder engagement as the regional entities determine spending for health improvement, medical capital and infrastructure projects, and regional involvement in efforts to address social determinants of health
- Regional Entity advises the Single Payer on the following:
    - Regional budgets for provider reimbursement
    - Acceptable methods of provider payment methodologies
    - Cost control efforts
    - Regional budgets for health improvement, medical capital and infrastructure projects, and ongoing stakeholder engagement
    - Provider contracts
    - How performance incentives should be targeted and measured
- The Single Payer may contract with a Regional Entity to serve as a Third Party Administrator or Administrative Services Organization to facilitate health care administration if this approach proves to be cost effective without undermining other values important to the success of the Single Payer

Single Payer Fiduciary Responsibilities

- Establishes the Single Payer budget to ensure adequate resources for both covered services and administrative costs to achieve the goals and vision of the Single Payer program
- Establishes and ensures appropriate restricted reserves
- Establishes budget for each region's delivery system
    - Regional Entities advise
- Establishes contracts with every provider including the establishment of payment levels and methods. Ensures that payments are adjusted for reduction in administrative costs
- Responsible for claims payment for covered services.
- Establishes and administers quality improvement and cost containment mechanisms
- Establishes budgets for the Regional Entities
    - Regional entities advise with input from their regions' stakeholders and community members
    - Includes funding for regional infrastructure and capital investments
    - Includes funding for regional investment for delivery system innovation
- Establishes a mechanism to receive gifts, donations and other revenue such as a foundation
- Continually establishes plans for emergency preparedness
- The Single Payer will be regularly subject to external audit

Single Payer Public Trust Fund – Example Legislative Language

- **The Oregon Single Payer Public Trust Fund** is established separate and distinct from the General Fund. The Oregon Single Payer Public Trust Fund may include:
    - Federal funds from Title XIX or XXI of the Social Security Act, and state matching funds, that are made available to the fund.
    - Contributions from the United States Government and its agencies for which the state is eligible provided for purposes that are consistent with the goals of the Oregon Single Payer program.
    - Moneys dedicated or appropriated to the Oregon Single Payer Public Trust by the Legislative Assembly for carrying out the provisions of the Oregon Single Payer Program.
    - Health care premium contributions.
    - Interest earnings from the investment of moneys in the fund.
    - Gifts, grants or contributions from any source, whether public or private, for the purpose of carrying out the provisions of the Single Payer Program.
- All moneys in the Oregon Single Payer Public Trust Fund are continuously appropriated to the Oregon Single Payer to carry out the mission and vision of the Oregon Single Payer program
- The Oregon Single Payer Public Trust shall be segregated into subaccounts as required by federal law. (*e.g. for Medicaid, Medicare*)

Required Single Payer Authorities

<u>The Legislature will need to:</u>

- Establish the Single Payer Public Trust Fund
- Establish the Single Payer and codify it as an independent public entity, such as OHSU or SAIF, responsible for providing universal, publicly funded health coverage for Oregonians

The Single Payer will need the following authorities:

Financial Authorities:

- To set its operating budget (subject to Legislative accountability)
- To set and distribute the budget for the regional entities
- To set up appropriate financial reserves
- To apply and accept grant dollars

Governance Authorities:

- To establish the Single Payer Board, any subcommittees or advisory committees and determine the Board/committee governance structure
- To oversee and delegate to the Regional Entities a budget for health improvement, medical capital and infrastructure projects
- To maintain government-to-government relationships with Tribes
- Government-to-government relationships with other states or countries

Plan Administrative Authorities:

- To establish covered benefits for all Oregonians
- To work (through the Regional Entities) with local governments on the single payer program
- To contract with providers
- To develop and implement payment methodologies, and pay for covered services
- To administer the program and ensure quality operations, including ability to subcontract for program administration if cost efficient
- To develop and implement program policies

Quality Assurance and Cost Containment Authorities:

- To implement quality assurance and cost-control measures to ensure safety, equity and patient experience
- To conduct bulk or multi-state purchasing approaches

Data Collection, Analysis and Distribution Authorities:

- To collect any needed data for tracking spending, utilization and reliable REALD/SOGI information to evaluate systemwide performance, quality, and equity
- To allow access to the above data

Specific current federal & state law/regulations may need adjustment for the Single Payer program and may need waiver approval or law changes to authorize. These could include:

Federal Law, state regulations and waiver authorities

- **Medicaid waiver authority**, including:
  - Amend Oregon's Medicaid 1115 demonstration waiver
  - Other waiver authority as needed
- **Medicare exemption or demonstration**
- **ACA requirements**, which could include:
  - Section 1332 waiver authority to diverge from ACA rules on how coverage is obtained, paid for, benefits provided or other current commercial plan requirements
- **ERISA pre-emption exemption**
- **Federal budget neutrality**
- **State law/regulation**

For consideration during a possible extension:

- Invest in services and supports to address social determinants of health
- Ensure that the workforce is working at the "top of their license," meaning providers practice to the full extent of their education and training, instead of spending time doing tasks that could be performed by someone with less education/training.