## Project Narrative

### (a) ELIGIBILITY

The Oregon Department of Consumer and Business Services (DCBS) has an Effective Rate Review Program as described in 45 C.F.R. § 154.301. Previously, Oregon met all the criteria for non-exempt associations; however, it did not meet all of the criteria for individual or for exempt small group (those groups with a small employer retention rate of 95%) association product types. Effective January 1, 2014, House Bill 2240 allowed DCBS to review rates for individual and small group coverage sold through associations, moving Oregon into an effective rate review status. Oregon received Cycle II funding and has drawn down more than forty (40) percent of Cycle II funds through the Payment Management System prior to July 20, 2014. Oregon will satisfy the reporting requirements established under section 2794(b)(1).

### (b) PAST PROGRESS AND CURRENT RATE REVIEW PROGRAM/PROCESS

**General Health Insurance Rate Regulation Information:**

All rates for individual and small employer health insurance must be approved as filed or as modified by DCBS, Insurance Division, before they can be used. The Project Narrative describes our proposal for the Baseline award of $1,179,000. We do not review or regulate large group health insurance rates.

**Health Insurance Rate Review and Filing Requirements:**

DCBS requires all rate filings for individual and small group health plans to include each item required in our product standards (Appendix B). After we receive a rate filing submission, our review process begins with the intake coordinator reviewing the filing to ensure it contains the required documentation. A market analyst and actuary then review the filing to determine if the contents meet the standards set by administrative rule. When the filing is deemed complete, the

intake coordinator posts the complete rate filing on our website and sends e-mail notifications to those who subscribe to e-notify.

Once the entire filing is posted, a public comment period begins with all comments being posted on our website. Using Cycle I, II, and III funds, we have enhanced this process by contracting with the consumer advocacy group OSPIRG (Oregon State Public Interest Research Group) to perform comprehensive reviews of select rate filings on behalf of Oregon consumers and small businesses. Their comments become a part of the public record and are highlighted on our website.

The filing is scrutinized by an actuary, who asks carriers follow-up questions to ensure the data received is accurate and addresses the proposed rate change. The questions and answers are posted to our website daily.

When the public comment period ends, the Insurance Commissioner meets with the rate review team, usually consisting of the product regulation manager, the market analyst, and the primary reviewing health actuary. After the team presents and discusses the filing, the Commissioner makes a final decision on rate approval, modification or disapproval. Once a decision is made, DCBS publishes a consumer-friendly rate decision summary explaining in plain language the reasons for our decision. When OSPIRG provides comments, we prepare a written response addressing its concerns and explain why we agree or disagree and how we addressed their concerns in our decision, if applicable. The OSPIRG comments and DCBS response are posted to our website. Finally, the intake coordinator posts the decision on the website and sends another e-notify, alerting subscribers of the disposition.

Oregon's rate review statutes require DCBS to ensure that the proposed rates are reasonable and not excessive, inadequate, or unfairly discriminatory, as authorized by ORS 742.005 and 743.018. DCBS has explicit authority to consider: historical and projected loss ratios, trends, and administrative costs; net income targets; investment income; surplus; and cost containment and quality improvement efforts. Beginning with 2015 rate filings, we collected insurer data for selected

cost and quality metrics. Though used only for informational purposes and not considered in the decision-making process for 2015 rates, we anticipate using this information in future years to assist in the rate review process. We also consider an insurer's overall profitability rather than just the profitability of a particular line of insurance.

Oregon required all carriers to submit their 2015 annual rate filings for individual and small group health plans by June 2, 2014, whether they intend to offer health benefit plans through the health insurance marketplace or not. Additionally, the Oregon Legislature passed Senate Bill 1582, allowing insurance carriers in Oregon the option of continuing to offer pre-2014, non-Affordable Care Act (ACA) compliant plans for members that are still on those plans. As a result, these carriers were allowed to submit new rate filings for these extended plans, with the same deadline of June 2, 2014. One result of this decision was that the rate review team had to complete a thorough analysis of 41 filings in two months. Their task was complicated by the complexity of assuring compliance with ACA requirements when necessary. We believe the common deadline and concurrent review process helped to ensure a stable and competitive market inside and outside our health insurance exchange, and would have been impossible to carry out without the additional staff resources supported by the Cycle II grant.

Beginning in Cycle II, DCBS convened meetings with actuaries representing Oregon's eight major health insurance carriers. We expanded this technical advisory group (TAG) to invite representatives from every insurer intending to do business in Oregon to participate in question and answer discussions about ACA implementation and the rate review process, with the goal that every carrier would submit complete and thorough rate filings. TAG met regularly up to the rate filing deadline. We anticipate TAG continuing to meet throughout Cycles II, III, and IV.

DCBS works closely with Cover Oregon, Oregon's supported state-based marketplace. Early collaboration with Cover Oregon included determining essential health benefits, working on risk adjustment and reinsurance projects, and developing a process for plan review, approval, and

certification to help ensure the exchange has the tools it needs to fulfill its Plan Management and Plan Certification requirements. DCBS's regulatory review and approval of health benefit plans is the first step in the plan management process, and DCBS collects much of the information needed to certify plans. DCBS is also assisting Cover Oregon in the transition to a federally-supported state based marketplace.

**Current IT and Systems Capacity:**

Oregon receives all of its rate filings through SERFF (System for Electronic Rate and Form Filing). With Cycle II funding, we automated processing to replace the manual processes to download new submissions and changes into our local Oregon data system. The automated download avoids duplication of work and potential errors. To allow rate comparisons between carriers for 2014 plans, we began posting rate tables on our website and continued that practice for 2015 plans. Further improvements should enhance our capacity to extract data more quickly and completely for use by the department, the exchange, and to inform the public.

**Current Resources Capacity for Reviewing Rates: Budget and Staffing:**

The insurance division has an annual budget of $10,442,228 to support all administrative, financial regulation, and market regulation activities. Of the annual budget, approximately $2,784,420 was spent this fiscal year on rate review. Of those funds, $711,582 came from Cycle II funds for rate review enhancements. In total, $338,582 was spent on salaries, $163,881 was spent on Other Payroll Expenses (fringe benefits), $4,671 was spent on travel and supplies, $126,749 was spent on contracts, $21,660 on transparency and efficiency enhancements, and $56,039 on indirect costs. Currently, eight staff members are responsible for Oregon's rate review process. This staff includes the Insurance Commissioner Laura Cali and the interim deputy administrator Russell Latham as well as the seven members of the rate review team. These staff members' biographies were previously supplied in Cycles II and III grant reports and staffing update letters and are attached

in Appendices C and D. The total number of rate filings in Cycles II and III are reported in quarterly and annual reports.

**Consumer Protections:**

As authorized by ORS 743.018 (3) and OAR 836-053-0471, DCBS posts all parts of the rate filings for individual and small employer health benefit plans on its website once they are deemed complete. Consumers can sign up on the DCBS website to receive an e-mail when an insurer files a rate request and again when we make a decision. Oregon law does not currently include a requirement that carriers give notice to a consumer before a rate increase is implemented.

Once a rate filing decision is made, DCBS posts a decision summary that describes in plain language the key factors underlying each rate filing action. Using Cycle II funding, we now hold public hearings for all individual and small group rate filings.

Our Consumer Advocacy Unit staffs a free hotline to answer consumer questions and take complaints. The advocates typically handle questions about plan benefits and how to use health insurance as well as provide bilingual consumer support. Our rate review grant coordinator is responsible for answering consumer questions regarding health insurance rate filings.

**Examination and Oversight:**

The state approves all rates before the plans may be sold. No formal enforcement action has been taken against insurance carriers during the past two plan years regarding health insurance rates.

DCBS now holds public hearings for every individual and small group health benefit plan rate change. These hearings are live streamed on the internet and recorded to be posted on our website. In person attendance has been sparse, but the live streams and recordings have generated larger audiences.

**Current use and collection of health care pricing data:**

DCBS actuaries scrutinize the basis for projected trend as part of evaluating the justification for requested rates. This typically consists of reviewing carrier-reported summary claims history and

the carrier's adjustments. Projected provider contract cost changes, as reported by carriers in filings, are also considered during rate review.

DCBS is authorized by 2009 legislation to consider carriers' health care cost containment and quality improvement efforts as part of its rate review. Every small group and individual rate filing is currently required to provide a description of changes in these efforts since their last filing. However, inconsistency in quality improvement/cost containment reports across carriers does not currently allow for meaningful and actionable comparisons for purposes of rate review.

The 2009 legislation also authorized the creation of the Oregon Health Authority (OHA) and the All Payer All Claims Database (APAC). The OHA is the agency responsible for health policy including public health, mental health and addiction services, Medicaid, research, and public employees' benefits. All carriers and licensed third-party administrators with at least 5,000 covered lives are required to report to the APAC. Other mandated reporters include pharmacy benefit managers, Medicaid managed care and coordinated care organizations, and entities with dual eligible special needs plans. APAC also includes claims information from Medicare parts C and D (now applying for parts A and B data). OHA contracts with Milliman, Inc. to collect and warehouse data on paid claims. Three types of data are collected quarterly:

- Eligibility (coverage dates, broad coverage categories, and patient demographics).
- Medical and pharmacy claims payments including patient cost sharing and deductible, diagnoses, treatments and other data fields.
- Provider location and specialty. (The public use data set has no provider information.)

The Oregon Health Care Quality Corporation (Q Corp) is an independent, nonprofit public benefit corporation dedicated to improving the quality and affordability of health care in Oregon by leading community collaborations and producing unbiased information. Q Corp's Board of Directors comprises providers, employers, consumers, policymakers, and health carriers. The Board receives

input from 11 committees, engaging approximately 150 volunteers. In Section (f) *Current status of Data Center activities*, Q Corp is described in detail, including data type, sources, analysis, privacy and data security and dissemination.

DCBS currently does not use health care pricing data from Oregon's APAC or the Q Corp, though that will change as the work under Cycle III progresses. DCBS and Q Corp will soon sign into agreements with OHA to gain access to APAC data. DCBS will use this information to enhance the rate review process and in efforts to improve health care pricing transparency.

We are fortunate to have both a state-run APAC and a nonprofit recognized by the CMS data sharing program as one of the first three Qualified Entities in the country. DCBS intends to strategically invest Cycle III funds in APAC and the Q Corp to support generating actionable information about the entire marketplace that will improve our analysis and allow comparisons among the carriers in future rate reviews.

In June 2013, Governor Kitzhaber charged the Oregon Health Policy Board (OHPB) with the task of recommending possible statutory and regulatory changes to ensure our state's triple aim goals (lower costs, better care, and better access) are met. OHPB's recommendations to the Governor included "opportunities to enhance the Oregon Insurance Division's rate review process" and "increase overall transparency and accountability". We are engaged in OHPB's process to implement these recommendations. DCBS staff participates in several workgroups that support the OHPB's evaluation of new and existing strategies to meet the triple aim. A key consideration is aligning efforts across Medicaid, Medicare and commercial insurance markets. The principles guiding the work include leveraging the coordinated care model, enhancing transparency, outcomes focused accountability, and securing quantifiable quality improvement and cost containment measures. The Insurance Commissioner briefed the OHPB on the rate review process and will, along with other DCBS staff, continue to provide technical assistance regarding actuarial analysis, insurance regulation, and rate review.

During Cycle III, DCBS convened OHA and Q Corp staff to discuss the roles of the APAC and the data center in possible rate review and pricing transparency strategies that are being considered by the OHPB, as well as other possible data needs that may enhance rate review and pricing transparency. Specifically, Q Corp and DCBS will jointly, in collaboration with OHA, develop specific implementation plans for products and services to be provided through the data center. This work is still in the early stages, with many decisions to be made, including what kinds of data to collect and how best to use the APAC. Once those determinations have been made, we will begin working to enhance the APAC and how to best use this pricing data in a meaningful way for consumers and rate review.

**(c) PLANS TO CONTINUE AND EXPAND ENHANCED RATE REVIEW**

Oregon has a strong and transparent rate review process. However Oregon has an ongoing goal to continue to find ways to improve our rate review process. We will use Cycle IV funds to enhance our existing process by adopting certain CMS rate review best practices including using market conduct authority to confirm rates are implemented as filed and also ensuring information in rate filing submissions is consistent with audited financial data.

**Use Market Conduct Authority to Confirm Rates Are Implemented as Filed**

DCBS proposes using Cycle IV funds to support targeted market conduct examination activity to confirm health benefit plan premiums charged to consumers are based on approved rates. Through DCBS' confirmation that these rates are being accurately implemented, carriers are less likely to seek unjustified increases and will endeavor to ensure that only approved rates are used. Confirmation of this fact should also help to generate consumer confidence in Oregon's rate review process.

DCBS may also use these examinations to validate accuracy of other data reported in rate filings which, as of this date, has not yet been determined. For example, DCBS currently requires carriers to submit a cost containment and quality improvement initiatives exhibit in rate filings.

Many carriers include information about how much money these initiatives save consumers. There may be an opportunity to review these savings during the examination process to determine whether the reported information is accurate.

We intend to use contract examiners to perform these examinations and the examinations will be conducted on carriers offering individual and small group health benefit plans in Oregon.

**Ensure Information in Rate Filing Submissions Is Consistent With Audited Financial Data**

DCBS will use Cycle IV funds to ensure that the financial data and support submitted during the rate filing process is consistent with audited financial statements received outside the rate filing process. Using existing grant staff, we intend to compare financial records with rate filings, paying special attention to areas such as Premium Earned, Claims Incurred, Administrative Expenses Incurred, and possibly Enrollment Data. DCBS would then use the rate review process to ask carriers about any variations between rate filings and financial documents.

**Continued Cycle IV Efforts to Increase Rate Scrutiny**

We intend to use Cycle IV funds to extend and refine our enhanced rate review process developed to date, especially taking lessons from the first simultaneous review of filings for plans effective January 1, 2014 and January 1, 2015. We also anticipate significant changes as a result of Cycle IV's support for improving rate review through the continued intake, analysis, and publication of health pricing data. As detailed in sections (f) and (g), DCBS intends to use Cycle IV funding to again contract with Q Corp with the goals of further incorporating health care pricing and performance data into rate review and making this information readily available to the public.

We also propose using Cycle IV funds to continue supporting a consumer organization to provide written comments and testimony on behalf of the public.

**Maintenance of Effort**

Our share of funds expended for rate review and Data Center activities under our proposal shall not be less than our (non-grant) funds expended for rate review and Data Center activities in the

fiscal year preceding the fiscal year for which the grant is awarded. Grant funds will only be used to enhance the state's existing rate review and Data Center efforts, and not as a substitute for existing funding for such efforts.

**(d) REPORTING TO THE SECRETARY ON RATE INCREASE PATTERNS**

DCBS will comply with the reporting requirement outlined in section 2794 of the Public Health Service Act, providing any individual and small group rate filing data requested by the Secretary of Health and Human Services (HHS). We will continue providing quarterly reports to HHS describing our progress in meeting grant objectives, including a summary of the progress made on the required grant milestones as well as updates on the Work Plan. We will provide analyses of selected issues such as difficulties and opportunities in collecting health care pricing data and meaningfully communicating that data to consumers and purchasers. We will be reporting any other data to HHS as requested. We will also provide copies of tools we develop, such as informational brochures and website updates. We will use the streamlined data submission, as outlined in the Standard and Special Terms and Conditions, to upload rate review data on a quarterly basis.

**(e) RECOMMENDATIONS ON INSURER PARTICIPATION IN EXCHANGE**

All rates for individual and small group health insurance must be filed and approved by DCBS before an insurer can offer plans in Oregon. By statute, approved rates must be actuarially sound, reasonable and not excessive, inadequate or unfairly discriminatory as described in (b). As a result, Oregon has no carriers with a pattern of excessive, unjustified rate increases. Rates are approved for market-wide use, inside and outside the exchange. DCBS collaborates with Cover Oregon to communicate rate information rapidly and in formats most useful to the exchange and to the public.

**(f) CURRENT STATUS OF DATA CENTER ACTIVITIES**

**Overview of Existing Data Centers**

As described in section (b), Oregon has both a state-run APAC database and a qualified data center. In addition, the OHA's Office of Health Analytics and the Oregon Association of Hospitals and Health Systems are data partners in the Health Cost and Utilization Project (HCUP) working to create a national resource of encounter-level hospital inpatient, outpatient and free-standing ambulatory surgery center discharge data. There is some duplication as a result of historic development and limits on having certain kinds of data (e.g., provider, carrier, patient level) in different databases. This provides short-term opportunities to cross-validate separate datasets and supplement one dataset from another as well as long-term opportunities to streamline collection, warehousing, analysis and reporting activities.

Using Cycle III funds, DCBS invested in APAC enhancement, including:

- Selecting, adopting, and implementing additional analytic tools to enable reporting useful information (e.g., risk adjustment, episode groupers, interactive online query tools) that builds upon Cycle III tools previously added.
- Continuing to enhance Cycle III data collection activities to include additional relevant information or indicators (e.g., market segment, plan design, health insurance exchange indicator).
- Expanding upon Cycle III Policy analysis and engaging stakeholders to further transparency and accountability.
- Ongoing testing of reporting formats for end-user comprehension

DCBS also invested Cycle III funds in the Q Corp, an existing data center, to produce products and services designed to increase transparency in health care quality and pricing, including analysis of yet to be selected cost drivers.

**Qualified Entity**

Q Corp has extensive experience in translating millions of claims into actionable information that can be used to improve care and reduce costs. Additionally, Q Corp has years of collaborative experience analyzing and presenting that information to patients, providers, purchasers, policymakers, and health carriers to guide clinical and health policy decision-making.

In November 2012, Q Corp became one of the first three organizations in the United States to become a Qualified Entity through the CMS data sharing program. Since 2008, Q Corp has been aggregating claims data from multiple payers to produce quality reports for consumers, providers, health plans, policymakers, and employers. In early 2014, ten of Oregon's largest commercial plans, two Medicaid managed care plans and the OHA's Division of Medical Assistance Programs contributed administrative medical and pharmacy claims data containing in excess of 400 million claim records from nearly three million unique members. Q Corp was awarded one of the first CMS Qualified Entity status designations and as a result acquired Medicare fee-for-service claims in spring of 2014. In late 2014, Q Corp anticipates adding data from five additional health plans that joined the collaborative during the previous year. Q Corp currently generates and reports more than 30 quality improvement and utilization measures. The database now includes 80 percent of the state's fully insured commercial population, 100 percent of the Medicaid population and 92 percent of the Medicare population. Q Corp data includes patient level detail and the ability to link individuals across plans and years. Currently, the database contains more than 3.6 million individual lives since 2006.

**Data Collection Authority**

The OHA's statutory authority and process for data collection and dissemination are described in section b) of this proposal and in the referenced appendices.

**Description of Existing Data Center**

Q Corp receives self-insured data from commercial plans that participate in its measurement

initiative. Self-pay data is not included in Q Corp's reports. Q Corp includes any qualified interested payers in its measurement initiative. Q Corp currently receives billed, allowed, paid, copay, coinsurance, deductible, and COB amounts at the claim detail line level. Q Corp is prohibited from revealing proprietary fee schedule amounts for any payer/provider. Q Corp received permission from 14 of 17 current data suppliers to report this data at an aggregate level beginning in 2014.

Q Corp collects enrollment, provider, medical and pharmacy claims. The detailed claims data includes information on diagnoses, procedures, providers and claims financial data (billed, allowed and paid amounts). Q Corp does not collect non-claims based financial transactions.

Q Corp contracts with Milliman, Inc., the same data aggregation vendor used by APAC. Direct patient identifiers are collected from each data supplier, along with other data elements that would identify a unique person. Milliman crosswalks the member information across the various data suppliers and generates a unique identifier for each individual. When Milliman shares patient level information with Q Corp, patients' identifiers are de-identified and other identifying elements such as name and birthdate are redacted. Q Corp and Milliman created a secure online system to deliver patient-level information to medical groups and providers. To promote the highest security and confidentiality, medical group administrators must enter into a Business Associate Agreement with Milliman and undergo an identity verification process before obtaining a username and password to access the system. This secure portal and delivery of patient-level data derived from claims used for quality improvement and better patient treatment is one of the first in the nation. Information provided on the secure portal is HIPAA compliant and handled according to HIPAA standards.

As previously stated, currently, Q Corp staff's access is limited to aggregate level data. However, Q Corp is in the process of executing new data use agreements that will allow analysts some access to patient level data to enhance data validation and conduct more robust analysis. This access will be tightly controlled and executed using industry standard Privacy and Security practices

to ensure all patients' individual and protected health information is secure. Specifically, Business Associate Agreements and Data Use Agreements have been rewritten and are currently being vetted by data suppliers (health plans and carriers). These new agreements will allow Q Corp to access Personal Health Information (PHI). Further, Q Corp's Privacy and Security Policies and Procedures have been written and implemented to support these changes.

Q Corp is actively planning the incorporation of clinical data in late 2014. Because integration of claims and clinical data is very complex, Q Corp is working with local stakeholders to identify priority programs from which these capabilities can continue to expand in subsequent years. One current priority area in Oregon is in perinatal care. Following a successful effort to implement a "hard stop policy" on early elective deliveries in Oregon hospitals, the March of Dimes asked Q Corp to lead the Oregon Perinatal Collaborative (OPC) Subcommittee on Data for Measurement and Improvement. The Subcommittee's launch emerged from the growing recognition of the need for aggregating claims and clinical data to produce meaningful information that is appropriate and useful to multiple audiences including clinicians, hospitals, health systems, purchasers, and consumers. The Subcommittee's objectives include developing a technology and business plan for data sharing and aggregation (i.e., an Oregon 'maternal data center'), providing clinical input into developing and reporting Q Corp's perinatal quality and cost measures, and identifying priorities for metrics needed to support best practices including care redesign.

The perinatal project builds upon Q Corp's previously successful pilot project which integrated clinical information from Electronic Medical Records (EMRs) with claims data. The pilot project demonstrated that EMR data can be successfully cross-walked to claims data, with nearly 95 percent of patients in the EMR data matching to Q Corp's claims database. The integration of claims and EMR data will provide information on care processes and health outcomes, giving a fuller picture of the health care system. Q Corp produces multiple reports for a variety of stakeholders throughout the year. Public reports for consumers and employers are available on the website

www.PartnerforQualityCare.org. Working with the Oregon Coalition of Health Care Purchasers, Q Corp is developing custom reports for employers to help them make decisions about the benefits they offer to their employees. Additionally, Q Corp's data suppliers receive a custom report to assess and compare their performance to each other and local and national benchmarks. Q Corp also produces a statewide report, *Information for a Healthy Oregon*, for health care professionals and policymakers.

Q Corp maintains extensive policies and procedures to ensure that protocols are followed by all staff, data users and vendors. Q Corp and its data services vendor, Milliman, have data use agreements with each data supplier and follow HIPAA standards and protocols for data access and transfer. Q Corp's secure ASP server, hosted by Milliman, is housed in a secure facility with a redundant power system and nightly back-ups transferred off-site. The network is protected by a firewall with automated system health and intrusion detection. Each user must sign in with a user ID and password using encrypted connections.

Milliman's Compliance Committee is responsible for developing firm-wide policies to ensure their offices are HIPAA compliant and protect client data using both cutting-edge technologies and traditional safeguards. Each Milliman office has one or more HIPAA compliance officer(s) responsible for ensuring that policies are fully implemented and followed in day-to-day operations.

Q Corp has publicly reported quality and utilization scores for clinics and hospitals in Oregon since 2009. Q Corp maintains a public reporting website (www.PartnerforQualityCare.org) which is regarded as a national model for reporting health care information to consumers. The website currently includes quality and utilization information, with plans to add cost information in 2014. Q Corp's partner organizations, including the Public Employees' Benefit Board, Oregon Educators Benefit Board and AARP Oregon, include Q Corp's data for consumers in their print and web-based newsletters. Q Corp also maintains social media networks to promote the website to consumers.

The website does not currently include health care cost information. However, Q Corp is planning to add the HealthPartners Total Cost of Care and Total Resource Use measures in 2014.

The public reporting website allows users to sort by geographic region using a mapping tool. Users can also sort by zip code, provider name, or clinic name. On the scores pages, users can sort by score or alphabetically. Users can view clinic specific pages, with scores for a clinic on one page along with demographic information about the clinic. A 2011 consumer usability study, done in partnership with the American Institutes for Research, observed how users navigate the site, what information they found most valuable and overall impressions of the site. Design and navigation changes made as a result of the usability study include the ability to search by zip code and provider and to view all of a clinic's scores on one page. Q Corp uses Google analytics to evaluate outreach efforts. Q Corp continues to add new information and measures, including patient experience scores for clinics added in June 2013.

Q Corp's data release policy and practices are described in *Fair Information Practices and Data Use Policies* (Appendix E). The Data Use Access Matrix outlines the types of data that is available to various categories of data users, the intended and prohibited uses of the data and the access processes and conditions. For government agencies and other non-provider stakeholder organizations involved in health care and payment reform activities, Q Corp encourages the use of aggregated quality, resource use, efficiency, effectiveness, and cost data and supporting information that is not considered personal health information. These aggregate data can be used in population health assessments, public health program planning, assessment and planning for health care and payment reform, and health policy deliberations.

As a neutral, multi-stakeholder organization, Q Corp works to ensure that staff, board, and committee members avoid any conflict, real or perceived, direct or indirect, between their own individual, professional or business interests and the interests of Q Corp. Q Corp's staff, Board of Directors and standing committees are required to sign a conflict of interest statement, including the disclosure of any conflicting relationships (Bylaws in Appendix F and Q Corp Board of Directors roster in Appendix G). The contract with Q Corp will require that the data center comply with the

Conflict of Interest Requirements stated in Appendix F of the Funding Opportunity Announcement and required by Section 2794 of the Public Health Service Act.

In the dozen years since its founding, Q Corp has received funding from government, nonprofit and business sectors. For 2014, Q Corp had a budget of $4,462,478 with a data center devoted budget of $704,300.

**g) PROPOSED DATA CENTER ACTIVITIES**

DCBS intends to use Cycle IV funds to build on Q Corp's existing work and enhance and expand the data center medical reimbursement data analytic capabilities. The Q Corp meets data center requirements, including:

- Nonprofit status. 501(c)(3)
- Health pricing data is being added to the Q Corp database in 2014 and reports incorporating these data with APAC data will be used to develop information and tools.
- Public disclosure, privacy and data security, and conflict of interest requirements.
- Pricing data to be provided to DCBS for rate review and other regulatory functions.

Q Corp collects multi-payer claims from seventeen data suppliers and recently expanded its Data Use Agreements to collect and report on cost-related (e.g., billed, allowed, and paid amounts) and resource-use related metrics as well as allowing access to PHI. As part of the enhanced Data Center, Q Corp proposes to work with staff at DCBS and the OHA to develop plans for expanding access to and reporting of price and cost information available through the State's APAC database. Enhancements to the Q Corp claims database and improved access to the State's APAC dataset will support pricing patterns analysis for expanded DCBS rate review activities and public reporting.

In 2013, Q Corp was awarded the Robert Wood Johnson Foundation's *Aligning Forces for Quality 4.0* multi-year grant. Under that grant, Q Corp convened a multi-stakeholder advisory

committee to provide strategic advice and guidance on the development of new products and services.

The committee discussed information and analytic needs by stakeholder group and prioritized needs (See Appendix H *Table 1. Inventory of Potential Cost of Care Products and Services*).

As part of Cycle III, Q Corp provided a list of numerous potential products and services that it could deliver. Given the limitation of time and resources, DCBS was only able to pursue a few of these items. Q Corp and DCBS jointly, in collaboration with OHA, developed specific implementations plans for the following products and services:

- *Price & Payment Variation Report/Tool* Q Corp will provide data and reports that show variation in health care prices and payments by provider setting (tied to insurer networks), geography, and over time. This information could also be adaptable to online, web-based formats and mobile devices and could be on the DCBS Oregonhealthrates.org site and other consumer sites.

- *Total Cost of Care + Quality Reports* These nationally recognized measures are the first standardized tools available to compare provider costs and efficiencies. DCBS could consider provider performance tied to insurer networks.

- *Targeting Yet to be Determined Cost Drivers* Q Corp will analyze cost drivers (chosen from a list of many) to evaluate health plan performance and cost. These reports will produce meaningful information for clinicians, hospitals and health systems, purchasers, and consumers and may also be considered during rate review.

With Cycle IV funds, DCBS will revisit the list of potential cost drivers, and select additional measures to pursue that could benefit consumers and enhance the State's rate review process. These cost drivers may be chosen by type of service, diagnosis grouping, hospital services, etc.

In addition to participating in the national effort to harmonize data collection by All

Payer Claims Databases, other datasets in Oregon include the hospital discharge data, annual hospital financial reports, and disease registries that may help give a more robust perspective.

**(h) COMMITMENT TO MENTOR STATES**

DCBS is already actively engaged in informally mentoring states. Several state insurance departments have asked us for guidance on how to create a rate review website similar to ours. Several states have also requested permission to use language and ideas from our *Consumer Guide to Health Insurance Rate Review*. We have been asked by CMS to assist Hawaii in rate review grant activities and will continue to assist other states in these activities and data center implementation as those opportunities arise.

**(i) EVALUATION PLAN**

Oregon proposes performing a self-evaluation for our final grant evaluation and will comply with all federal evaluation requirements. DCBS will evaluate the effect of Cycle IV funds on:

- *Enhanced rate review*. For 2014 filings, the first year of ACA implementation and launching Cover Oregon, we relied on pre-ACA claims data and projections about the effects of benefit changes and merging high risk and uninsured populations. For 2015 filings, only a few months of claims data was available by the time filings were made. For the 2016 filings, we will have more than a year of claims data and understand the impact of the reinsurance, risk adjustment, and risk corridor. We intend to evaluate whether having the staffing to do a critical analysis of each rate filing results in containing costs and maintaining a competitive market.
- *Health care pricing data*. The two major areas we intend to evaluate are how the availability of health care pricing data affects rate review and rate decisions and the degree that consumers are engaged with using the related tools in their decision making. As DCBS collaborates with Q-Corp, we will identify specific measures related to the agreed upon scope

of work. These measures might include: the number of websites and consumers making use of the publicly available tools that report on price and performance; how this data was used in rate review and to what extent it affected the process and decisions. DCBS will submit a detailed evaluation plan in January 2015, when we have agreed to specific scopes of work and determined the specific measures of success.

- *Market conduct examinations*. DCBS will report on the number and level of insurer compliance for market conduct examinations completed during each quarter. DCBS will also report on collaboration with carriers to ensure that report findings and recommendations are complied with.
- *Financial reviews*. DCBS will review insurer financial statement data for each rate filing submission to compare it with financial information provided in the rate filing. We will question carriers on any recognized discrepancies and work with carriers to correct any reporting errors. We will report on the effectiveness of these reviews as we receive filings.