Coordinated Care Model Alignment Workgroup

Recommendations for the
Oregon Health Policy Board

11/5/2013

Background:
In a letter to the Oregon Health Policy Board (OHPB) dated June 3, 2013, Governor John Kitzhaber, M.D. requested recommendations for aligning the Oregon's coordinated care model (CCM) principles to the Public Employees' Benefit Board (PEBB), the Oregon Educators' Benefit Board (OEBB), Cover Oregon (CO) and the broader market. This request builds on the success of Oregon's broader health system transformation by using the state's purchasing and purchasing facilitation lever to signal to the delivery system that there are higher expectations for enhanced care coordination and innovative methods for reducing costs, reducing disparities, and improving quality of care. To develop recommendations in response to the Governor's request the OHPB approved a chartered workgroup, the Coordinated Care Model Alignment (CCMA) workgroup, and charged it with developing recommendations detailing specific CCM principles and attributes for adoption as well as timelines and outcomes which facilitate alignment within their respective organizations.

The Director of the Oregon Health Authority (OHA) Bruce Goldberg, M.D. appointed two board members from PEBB, OEBB and Cover Oregon as members of the workgroup. Workgroup membership is listed below.

Sean Kolmer (Chair), *PEBB*	Steve McNannay, *OEBB*	Gretchen Peterson, *Cover Oregon*
Paul McKenna, *PEBB*	Alison Little, *OEBB*	Ken Allen, *Cover Oregon*

Cover Oregon is Oregon's state-based health insurance marketplace where individuals, families, and small employers (1-50 employees) can shop for, compare and enroll in health insurance plans and access financial assistance to help pay for coverage. In 2016, Cover Oregon is expected to expand to employers with 51-100 employees. Cover Oregon operates at no cost to the state. It is funded by federal grant dollars through 2014; after that, it will be self-sustaining through an administrative fee charged to insurance carriers. It is anticipated that over 200,000 Oregonians will purchase health insurance through Cover Oregon.

PEBB designs, contracts and administers medical, dental, vision, life, accident, disability and long-term care insurance, flexible spending accounts, and an employee assistance program for state employees and their dependents. The Board also offers benefit plan options for retirees not yet eligible for Medicare and for individuals in other participating groups, such as certain self-pay groups and semi-independent state agencies. PEBB's total membership is approximately 127,000 individuals. PEBB's Benefit Budget for the 2013-2015 biennium is $1,531,997,391. These funds are used to pay for all the covered benefit plans offered by PEBB for eligible members.

OEBB was created in 2007 and, similar to PEBB, provides medical, dental, vision, life, accident, disability and long term care insurance, flexible spending accounts and an employee assistance program for 240 of Oregon's educational employees, including employees at K-12 grade school districts, education service districts (ESDs), community colleges and some charter schools. OEBB also offers a health savings account. Currently, 145,785 individuals are eligible to enroll in OEBB. OEBB's Benefit Budget for the 2013-2015 biennium is $1,628,294,000. These funds are used to pay premiums for all the various benefit plan options offered by OEBB for members or educational entities that make selections on behalf of members.

Membership for OEBB and PEBB could expand in January of 2014 and 2015, respectively, as a result of Oregon House Bill 2279 (2013). HB 2279 amends PEBB's and OEBB's governing statutes to allow local governments or local government employees to voluntarily participate in the benefit plans offered by PEBB or OEBB. There are nearly 900 city, county, or special districts that are eligible to participate, with an estimated 50,000 employees.

To date, OEBB has received notice from Josephine County that they will join OEBB and begin offering benefits to their employees and their families effective January 1, 2014. OEBB anticipates this would be approximately 700 additional members eligible to enroll in benefit plans offered through OEBB. An employee group within Clatsop County has expressed interest in joining OEBB in January 2014, but there is no firm commitment at this time. PEBB will be able to enroll local government groups in its benefit plans beginning January 2015 and expects to know more about these groups' level of interest over the next six to nine months.

PEBB, OEBB, and Cover Oregon are responsible for offering high-quality and affordable health insurance plans to a vast number of Oregonians in all regions of the state. Increasing alignment and collaboration among these organizations creates a significant opportunity to positively impact the delivery system statewide.

Recommendation 1: Each entity should adopt the principles of the coordinated care model.

The overarching goal of each state purchaser and purchaser facilitator in the CCMA workgroup is to improve the health of those they serve, improve the quality of care delivered and control costs. Similarly the workgroup recognizes that spreading the coordinated care model principles into their respective organizations is a vital "next step" in Oregon's Health System Transformation (se CCM principles below). Spreading the coordinated care model will help PEBB, OEBB, and Cover Oregon better meet the triple aim by identifying appropriate coordinated care model attributes for adoption and determining detailed opportunities for implementing those attributes within their respective organizations. The workgroup understands the need to help members improve their health through best practice care models such as those that emphasize preventive and primary care as well as the potential for their respective organizations to hold health plans and providers accountable for the money they spend by paying for and measuring achievement and process-related health outcomes. The group's work establishes a higher standard of care for health plans and providers that prioritizes efficiency, coordination, and patient-centered care for the members for whom they facilitate the purchase of or purchase health coverage for. By jointly establishing common priorities in purchasing health care while simultaneously increasing active engagement and collaboration across agencies, these organizations will help build a sustainable healthcare delivery system and a healthier Oregon.

By adopting principles of the coordinated care model throughout PEBB, OEBB, and Cover Oregon contracts with health insurers, a large percentage of commercial purchasing will be coordinated and aligned for the delivery system to begin changing its business model to achieve better health, better care and lower costs. For example, in the future, successful bids and definitions for request for proposals, qualified health plans or other contract relationships would demonstrate adoption of model features, such as fixed rates of growth that encourage flexibility and are outcome-based, delivery system integration and coordination, and performance measurement.

The coordinated care principles are below and can be implemented in different ways through different levers in each organization.

1. Do what works. Use best practices to manage and coordinate care.
Coordinating care through evidence-based best practices can support providers in attaining the highest quality of care in the most efficient manner.

2. Share responsibility for health among providers, individuals and health plans.
When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and patients/consumers can share responsibility and decision-making for care, while coming to joint agreement of accountability for individual health behaviors.

3. Measure performance.
Strengthening performance measurement alignment across purchasers eases the burden of reporting for providers and establishes an accurate picture of health and performance outcomes.

4. Pay for outcomes and health.
Alternative payment methodologies (APMs) such as value-based payments, shared savings, and offering incentives for quality outcomes instead of volume-based fee methodologies supports better care and better quality of care while providing flexibility without compromising access to care or services.

5. Provide information so that patients and providers know price and quality.
Readily available, accurate, reliable and understandable cost and quality data can help patients understand health care plan choices, and share responsibility in treatment, care management, and other health care decisions. Increased transparency on price and quality can also lead to increased accountability for providers.

6. Maintain costs at a sustainable fixed rate of growth.
Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through a fixed rate of growth approach is foundational to health care transformation in Oregon.

Recommendation 2: Each Board should adopt a shared timeline with accountabilities for implementation of coordinated care model alignment.

Alignment with the principles of the coordinated care model will not be instantaneous, sequential nor happen in the exact same way across these entities. PEBB, OEBB, and Cover Oregon should begin to incorporate these principles in RFP development, contracts, renewals, and other means, where appropriate. These organizations' respective boards are responsible for alignment and should begin their respective conversations using the timeline in Appendix C as a framework, which reflects key dates and opportunities for alignment over the course of the next four years.

Recommendation 3: PEBB, OEBB, and Cover Oregon should jointly charter a group to oversee continued alignment between the three organizations.

It is essential that PEBB, OEBB, and Cover Oregon continue these alignment efforts following the completion of this workgroup. Actively coordinating and connecting this work across organizations will further enhance the sustainability and efficiency of the model while ensuring that best practices are shared. The following actions are recommended:

1. Ensure that alignment across metrics is addressed by establishing it as the first priority for the jointly chartered group.

2. Support collaborative and coordinated procurements among PEBB, OEBB, and Cover Oregon to allow these groups to explore where there might be efficiencies gained from undergoing joint or parallel processes for obtaining similar categories of professional services (e.g., contract one data analytic company to examine claims data for all three organizations).

3. Convene staff and board leadership from PEBB, OEBB, Cover Oregon and the broader market through learning collaboratives, potentially through the OHA Transformation Center, where these organizations can continue to share opportunities, challenges, and innovative ideas for coordinated care model alignment in purchasing and purchasing-related issues.

Recommendation 4: To the extent practical, alignment efforts in the future should consider the role of the Oregon Insurance Division as the regulator for the individual and small group markets in Oregon, which includes plans certified through Cover Oregon.

The Oregon Insurance Division can facilitate the creation of a statewide health insurance market that is committed to the coordinated care model.

Additional background information and analysis supporting these recommendations is available in the following attachments:
Appendix A: Governor Kitzhaber's June 2013 letter to the Oregon Health Policy Board
Appendix B: The Coordinated Care Model Alignment work group charter
Appendix C: Proposed contracting timelines for PEBB, OEBB, and Cover Oregon
Appendix D: Expanded definitions, attributes, and examples of the Coordinated Care Model principles
Appendix E: Crosswalk of current Coordinated Care Model alignment across PEBB, OEBB, and Cover Oregon
Appendix F: Comparison of quality measures to be reported by PEBB, OEBB, Cover Oregon QHPs, and CCOs

JOHN A. KITZHABER, MD
Governor

June 3, 2013

Oregon Health Policy Board
Chair Eric Parsons
Vice-Chair Lillian Shirley

Dear Chair Parsons and Vice-Chair Shirley:

As you and the Board are well aware, beginning in 2014, the Affordable Care Act (ACA) will significantly expand coverage to thousands of currently uninsured Oregonians and alter the regulations governing the individual and small group markets. While the ACA makes historic, nationwide changes in coverage expansion and the regulation of the individual and small group markets, I believe there is an immediate need to focus on how to better align ACA implementation activities with our current reform efforts. I want to ensure that our triple aim goals of lower costs, better care and better health across all markets are achieved. To that end, concurrent with the ACA, we have an opportunity to create an environment for the commercial marketplace in Oregon that moves toward one characterized by models of coordinated care and growth rates of total health care expenditures that are reasonable and predictable.

For this to occur, I am asking that by the end of this year, the Oregon Health Policy Board take on the task of recommending to me and the Legislature, possible statutory and regulatory changes necessary to ensure our triple aim goals are met. I would anticipate that such recommendations would include, but not be limited to:

- strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- opportunities to enhance the Oregon Insurance Division's rate review process;
- alignment of care model attributes within PEBB and OEBB contracts;
- alignment of care model attributes within Cover Oregon's qualified health plans.

Thanks to all of your hard work and leadership over the past several years, Oregon has made significant progress in reforming its health care delivery system. Across the state, communities have begun transforming to deliver more effective, efficient care. Critical partnerships are developing to reward quality care, promote prevention and wellness and manage chronic diseases and are building new networks, products and contracting models.

We have an amazing opportunity to leverage all of your great work with the implementation of the ACA and I look forward to working with you to achieve further success.

Sincerely,

John A. Kitzhaber, M.D.
Governor

MJB/smg

Oregon Health Policy Board
Coordinated Care Model Alignment
Work Group Charter

Approved by OHPB on 2 July 2013

I. Authority

The Oregon Health Authority (OHA), under Governor Kitzhaber's June 2013 letter to the Oregon Health Policy Board (Board), is establishing a public process to inform healthcare cost containment strategies and recommend delivery system alignment actions.

The goal is a sustainable, affordable, coordinated and high quality health care delivery system.

The Oregon Health Plan (OHP), Oregon's coordinated care delivery model, delivers care through a fixed global budget and maintains costs at a sustainable level. Under this model healthcare is coordinated across the delivery spectrum through locally accountable Coordinated Care Organizations (CCOs). Flexibility to innovate, alternative payment methodologies, and shared responsibility among local providers, patients and health plans are other key aspects of the model. CCOs are charged with delivering healthy outcomes and their ability to meet this charge is measured quarterly through performance data.

As the policy-making and oversight body for OHA, the Board establishes the Coordinated Care Model Alignment Work Group to provide input on potential regulatory delivery system alignment improvements. The Work Group will be guided by Governor Kitzhaber's June 2013 letter to the Board, the Board's 2010 report *Oregon's Action Plan for Health*, and by Oregon's health system transformation goals:

- improving the lifelong health of all Oregonians;
- improving the quality, availability and reliability of care for all Oregonians, and;
- lowering or containing the cost of health care so that it is affordable for everyone.

This charter shall expire on November 30, 2013 or when the Board determines that the charter has been fulfilled, whichever is sooner.

DRAFT

II. Scope

The Coordinated Care Model Alignment Workgroup is charged with providing draft recommendations and implementation actions for the consideration of the Oregon Health Policy Board.

Purchasers to be covered in recommendations include but are not limited to:

- PEBB (to include currently underway RFP process for 2015 services)
- OEBB
- Cover Oregon
- Other public and private organizations

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

The work group will not be asked to approve the final Board recommendations to the Legislature.

III. Deliverables

The workgroup will submit recommendations in a report to the Board before November 1, 2013.

IV. Timing/Schedule

The Workgroup will complete its work by November 2013; it will meet monthly at a location to be determined. The workgroup will meet at the discretion of the Board.

V. Staff Resources

Chairs: TBD

Staff: TBD, Jeff Scroggin

VI. Work Group Membership

Workgroup members are appointed by Director Bruce Goldberg. The workgroup will have a chair that will represent the group and present at Board meetings.

Membership: TBD

Draft Proposed Timelines

		PEBB	OEBB	Cover Oregon
2013	Sep	Med/Pharmacy RFP issued for 2015		
	Oct			Enrollment period for 2014 plans
	Nov	RFP closes, PEBB reviews proposals		
	Dec			
2014	Jan	Competitive proposals selected and interviewed	Med/Dental contract renewal period for Oct 2014 to Sept 2015 plan year	
	Feb	Final awards		
	Mar	Contract negotiations		
	Apr			
	May	Contracts signed by 6/1	Complete contract renewals for Med/Dental for Oct 2014 to Sept 2015 plan year	
	Jun	Open enrollment planning		
	Jul			
	Aug			
	Sep	Enrollment period for 2015 plans	Enrollment for Aug 2014-Sept 2015 plans	
	Oct			
	Nov			
	Dec			RFA released for carriers for plan benefit year 2016
2015	Jan	Contract initial plan year begins; initial 2016 renewal letters sent*	Med/Dental contract renewal period for Oct 2015 to Sept 2016 plan year	Response to RFA due
	Feb	2016 renewal responses due; reviewed by Board for approval of plan designs/rates		CO reviews RFA responses for approval by early April
	Mar			
	Apr			Approved carriers file plans/rates with DCBS
	May			Cover Oregon certifies plans
	Jun	Contract amendment and member handbook update period	Begin design process for med/dental/vision RFPs for Oct 2016 to Sept 2017 plan year	
	Jul		Complete contract renewals for med/dental plans for Oct 2015 to Sept 2016 plan year	
	Aug		Enrollment for Aug 2015-Sept 2016 plans	
	Sep			
	Oct	Complete contract renewals for 2016 plan year		2016 plans publicly available
	Nov			
	Dec		Release RFPs for med/dental/ vision for Oct 2016 to Sept 2017	
2016	Jan			
	Feb		Selection process for med/dental/vision plans for Oct 2016 to Sept 2017	
	Mar			
	Apr			
	May			
	June			
	July			
	Aug		Contracts signed for Oct 2016 to Sept 2017 plan year& Enrollment period for 2016-17 plans	
	Sep			

Note: PEBB and OEBB will jointly release an actuary RFP during mid-2014. PEBB may also release a wellness RFP in 2014

*Timeline for PEBB contract renewals for subsequent plan year (2016) are modeled after the PEBB 2013 contract renewal timeline

Principles of Oregon's Coordinated Care Model

Coordinated Care Model Alignment Work Group

Examples and Descriptions

1. Use best practices to manage and coordinate care

Coordinating care through evidence-based best practices can support providers and health care facilities in attaining the highest quality of care in the most efficient manner.

Examples:

- Single point of accountability
- Patient and family-centered care (e.g., patient-centered primary care homes PCPCH)
- Increased coordinated care around long term care services and support (LTSS)
- Team-based care across appropriate disciplines
- Cost containment and quality improvement plans for managing care for 20 percent of population driving 80 percent of costs
- Plans for prevention and wellness, including addressing disparities among population served
- Broad adoption and use of electronic health records

Contract examples:

"PHP agrees to continue developing and implementing the medical home concept and providing PEBB with data and findings related to the success or challenges learned from the implementation of medical home pilots. Programs will include: Asthma, Diabetes, Coronary Disease, Chronic Obstructive Pulmonary Disease, Heart Failure." *PEBB January 2013 contract*

2. Share responsibility for health

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and patients/consumers can share responsibility and decision-making for care, while coming to joint agreement of accountability for individual health behaviors.

Examples:

- Shared decision-making for care among patients and providers
- Providers can increase education for consumers/patients on care management, personal health behaviors, treatment options, etc.
    - Payer can ensure screenings, well-child visits, other preventive care measures, supportive chronic care management techniques are incentivized
- Payers can support patients/consumers in becoming accountable for personal health behaviors through evidence-based wellness incentives (e.g., gym membership subsidies, smoking cessation programs, weight loss programs, etc.), payment for preventive primary care, etc.

Contract example:

"Health Engagement Model. PHP will provide health tools that will allow PEBB members to comply with the required components of PEBB's Health Engagement Model. HEM tools accessible through the online portal must include an Online Personal Health Assessment (PHA), Health Conversation modules, and other supporting information as required by PEBB." *PEBB January 2013 contract*

3. Measure performance

Strengthening performance measurement alignment across purchasers eases the burden of reporting for providers and establishes an accurate picture of health and performance outcomes.

Examples:

- Demonstrated understanding of population served can improve health outcomes at all levels and establishes a baseline dataset
- Establish shared metrics with clear targets
- Performance measurement should include metrics related to health care workforce issues with a demonstrated connection to health care quality, such as staff turnover rates, existence of labor-management partnerships, and availability of protection for whistleblowers.
- Share strategies for improvement on quality, cost and access metrics
- Using data from metrics can ensure adequate provider supply in needed areas is supported.
- Utilize aligned metrics across purchasers

Contract example:

"Cover Oregon will identify a list of quality measures to be used to evaluate Carrier's QHP performance and effectiveness and assign a QHP grade. The measures chosen will be measures already established by nationally or locally recognized entities such as NCQA, CMS, and Oregon Health Care Quality Corporation (Quality Corp). Cover Oregon will work with an independent contractor, Quality Corp, to collect all data necessary to assign a quality rating for each QHP. Carrier will join the Quality Corp measurement and reporting initiative and will submit its administrative claims data to Quality Corp on a regular schedule, at minimum biannually." *Cover Oregon Final Medical Contract 2013*

4. Pay for outcomes and health

Alternative payment methodologies (APMs) such as value-based payments, shared savings, and offering incentives for quality outcomes instead of volume based fee methodologies supports better care and better quality of care while providing flexibility without compromising access to care or services.

Examples:

- Global budgets (e.g., CCOs are in part defined by a new payment model that holds them accountable for the total cost of care (behavioral, physical and dental health care) for enrolled members)
- Tiered payments for PCPCHs
- Value-based payments that providers are incentivized to provide high-quality, efficient care.

Contract example:

"PEBB endorses innovative payment models that move away from fee-for-service reimbursement and reward for cost and quality outcomes. PHP will develop and implement payment models that may include (but are not limited to) withhold, global budgets, capitation, and other reimbursement methods based on Patient Centered Primary Care Home Standards and Measurements as developed from time to time by the Oregon Health Authority." *PEBB January 2013 Contract*

5. Provide information so that patients and providers know price and quality

Readily available, accurate, reliable and understandable cost and quality data can help patients understand health care plan choices, and share responsibility in treatment, care management, and other health care decisions. Increased transparency on price and quality can also lead to increased accountability for providers.

Examples:

- Providing information to consumers that explains enrollment options and plan choice
- Providers and plans working together to provide consumers with an estimated quote for a medical procedure in advance of treatment
- Plans and providers sharing data back and forth on quality outcomes and price

Contract examples:

"Price and Quality Transparency**:** These innovations provide useful and easily accessible cost and quality information to guide enrollees in understanding their own out-of-pocket costs for services, and in comparing the quality and safety of providers. They may include decision-support tools to help enrollees understand the availability and potential risks of treatment options for their disease." *OEBB RFP Scope of Work 2009*

6. Establish a sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through a fixed rate of growth approach is foundational to health care transformation in Oregon.

Examples:

- Improving care coordination at all points in the system
- Integrating health system delivery budgets across the spectrum
- Testing, acceleration, and spread of effective delivery system & payment innovations

Contract example:

"The Contractor shall deliver to OEBB enrollees a care management process that fully integrates medical, behavioral, acute, chronic care and patient education into a seamless experience. Contractor's program shall help enrollees manage their chronic conditions and diseases to achieve optimum health. Such a delivery model shall, to the extent possible, be evidence-based and produce clinical outcomes and financial impacts that can be measured quarterly and annually." *OEBB Contract 2009.*

PEBB, OEBB, and Cover Oregon Alignment with the Coordinated Care Model Principles:
November 2013

The information below provides a picture of PEBB, OEBB, and Cover Oregon activities, programs, contract language and operations that already align under the Coordinated Care Model (CCM) principles, as well as opportunities for future alignment.

Items indicated for PEBB are reflected in PEBB's current medical contracts and should be furthered through its current Medical Request for Proposals (RFP) process. Items for OEBB were extracted from its current 2013-2014 medical contracts. Cover Oregon items were gathered from the generic medical contract for the 2014 plan year and for the Request For Applications (RFA) put out in 2013.

Items were included based on whether the activity/program furthered the effort toward alignment with a CCM principle. Since many items can impact multiple CCM principles, the right-hand column indicates additional CCM principles that may be applicable to the item. For example, chronic disease case management is primarily a best practice for managing care (CCM Principle #1), but also can help share responsibility for health (CCM Principle #2), and may contribute to maintaining costs at a sustainable fixed rate of growth (CCM Principle #6).

Coordinated Care Model Principle	Program or Operation	PEBB	OEBB	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
1. Do what works. Use best practices to manage and coordinate care	Quality Improvement program or strategies	X	X	X	E.g., Aligning Forces for Quality, e-value8, Leap Frog. To participate in the Exchange, carriers are required to implement and report on a quality improvement strategy or strategies consistent with §1311(g) of the Affordable Care Act (ACA). Under §1311(g), a strategy is a payment structure that provides increased reimbursement or other incentives for improving care coordination, chronic disease management, prevention of hospital readmissions, improvement of patient safety, implementation of wellness programs, or reduction of health care disparities.	3, 6
	PCPCHs or Medical Homes	X	X	X	Including adoption of the Patient-Centered Primary Care Home Standards and Measurements developed by OHA	3, 4, 6

Coordinated Care Model Principle	Program or Operation	PEBB	OEBB	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
1. Do what works. Use best practices to manage and coordinate care	Use of Electronic Medical Records and Health Information Exchange (HIE)	X	X	X	Contractor agrees to make commercially reasonable efforts to request its providers to adopt and demonstrate the meaningful use of certified EMRs and promote health information exchange.	
	E-prescribing	X	X		Contractor supports the implementation of e-prescribing access for all providers	
	Case management or chronic disease management programs	X	X	X	E.g., congestive heart failure, cardiovascular disease, asthma, diabetes and maternity management.	2, 6
	Behavioral and Physical Health Integration				Develop and implement a health care delivery model that integrates mental health and physical health care and addictions. This should specifically address the needs of individuals with severe and persistent mental illness.	
	Telehealth programs for members	X	X		For PEBB: PHP, through Providence Health eXpress, will establish and maintain telehealth stations in state buildings for active PEBB Members enrolled in either a Providence Health Plan (PHP) or Kaiser medical plan. A "telehealth station" is defined as a confined and private room with a videoconferencing unit for the encounter and with a direct connection to a PHP intake specialist. For OEBB: Covered medical services, delivered through a 2-way video communication that allows a professional provider to interact with a member who is at an originating site, are covered. For OEBB: Covered medical services, delivered through a 2-way video communication that allows a professional provider to interact with a member who is at an originating site, are covered.	2

Coordinated Care Model Principle	Program or Operation	PEBB	OEBB	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
1. Do what works. Use best practices to manage and coordinate care	Administrative simplification	X	X		From OEBB and PEBB contracts: Contractor acknowledges that there are significant opportunities to improve the efficiency and timeliness of administrative processes and transactions between providers and health plans. Therefore, Contractor shall: (a) Continue its active participation in administrative simplification efforts undertaken by the OHA, DCBS and the Oregon Health Leadership Council;(b) Comply with the rules of DCBS requiring uniform standards for insurers; and, (c) Use commercially reasonable means, to include language in all its contracts with professional and institutional providers, as those contracts requiring them to conduct all administrative transactions electronically in accordance with standards...	
	Language and cultural considerations for members			X	From Cover Oregon RFA: How do you communicate important information about your health benefit plans and company policies in a culturally and linguistically appropriate manner with members?	
	Provider diversity and cultural competence				E.g., cultural competence training for providers; provider composition reflects Member diversity; non-traditional health care workers composition reflects member diversity	1,2
2. Share responsibility for health among patients, providers, and plans	Health Risk Assessment, with incentives for members who participate	X	X		E.g., Health Engagement Model (PEBB) and Health Futures (OEBB)	5, 6
	Wellness program or activities for members	X	X		E.g., weight management program, smoking cessation program, diabetes management program, MoodHelper, etc.	1, 5, 6
	Online team-based Worksite Wellness program	X	X		E.g., Healthy Team, Healthy U	1, 5, 6

Coordinated Care Model Principle	Program or Operation	PEBB	OEBB	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
2. Share responsibility for health among patients, providers, and plans	Fitness Facility Subsidy program	X			Provides partial reimbursement of fitness facility membership costs for participants that meet defined minimum attendance requirements for attending the qualifying fitness facility where they have a membership. New to PEBB in October 2013.	
	Inclusion of preventive services at no-cost or low-cost to members	X	X	X	E.g., annual physical exams, mammograms, well-baby or well-child visits, immunizations, colorectal cancer screenings, etc.	1, 6
	Shared decision-making tools	X	X		E.g., online tools for members and providers including health trackers, medical libraries, E-DOC, evidence-based information that can help members compare treatment options for common chronic conditions (e.g., low back pain or hypertension).	5
	Value-Tier medications	X	X		OEBB and PEBB instituted value tier medications for 5 chronic conditions: diabetes, asthma, heart conditions, high blood pressure and cholesterol. PEBB offers barrier-free prescription drugs for some mental health and behavioral health conditions	4, 6
	Community Health Assessment and Improvement				Providers and plans can incorporate information from community health assessments and community health improvement plans, including those developed by Coordinated Care Organizations, as part of a strategic population health and health care system service plan for the community served by the plan and providers	
3. Measure performance	C-Section goal	X	X	X	Attempt to use reasonable measures to reduce purely elective inductions and primary and repeat cesarean deliveries at <39 weeks of gestation.	4, 6
	Readmission goals	X	X	X	Contractor shall provide a goal of reducing re-admissions and report on its efforts to decrease re-admission rates	4, 6
	HEDIS Reports	X	X		Report OEBB-specific and commercial book of business scores for selected HEDIS measures	
	Large Claims Reports	X	X		Large Claims Report by case with diagnosis of aggregate claims over a $100,000 threshold by month for the Plan Year	

Coordinated Care Model Principle	Program or Operation	PEBB	OEBB	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
3. Measure performance	Enrollee Satisfaction surveys	X	X	X		2
	Metrics to be reported	X	X	X	E.g., Cover Oregon proposed metrics: Breast cancer screenings; Comprehensive diabetes screenings; Cholesterol management (LDL test) for patients with cardiovascular conditions; Flu shots; Annual monitoring for patients on persistent medications; Inpatient utilization – general hospital/acute care (IPU); Initiation and engagement of alcohol and other drug (AOD) treatment (IET); Antidepressant medication management; Prenatal and postpartum care; Well-child visits in the first 15 months of life, six or more; Getting needed care without delay; Overall rating of health care quality; and Overall rating of health plan.	5
	Strategies and Evidence-based Outcomes Workgroup		X		OEBB Strategies and Evidence-based Outcomes Workgroup (SEOW) in place to review data and make recommendations on benefit changes to improve cost and quality (not specifically in contract but all reports are reviewed by this group)	
4. Pay for outcomes and health	Tiered payment for Patient-Centered Primary Care Homes (PCPCHs)	X	X		PEBB and OEBB provide an age-adjusted, per-member-per-month incentive payment to Tier 2 or Tier 3 recognized PCPCHs	1, 2
	Innovative Payment Reforms or Alternative Payment Methodologies (APMs)	X	X	X	Endorses innovative payment models that move away from fee-for-service reimbursement and reward for cost and quality outcomes. Contractor will develop and implement payment models that may include (but are not limited to) withhold, global budgets, capitation, reference pricing, bundled service payments, blended rates, pay-for-performance, and other reimbursement methods	1, 6
	Patient Safety Reporting	X	X	X	Requires that contractor uses commercially reasonable means to include specific language in contracts with hospitals, such as requiring Adverse Events Reporting programs, surgical checklists, participation in Non-Payment for Serious Adverse Events, etc.	1, 5

Coordinated Care Model Principle	Program or Operation	PEBB	OEBB	Cover Oregon	Notes, Contract Language, and Examples	Other applicable CCM Principles
4. Pay for outcomes and health	Additional Cost Tier Co-Pays (ACT)	X	X		ACT increases member cost-sharing for certain services often considered to be preference sensitive. Members are encouraged to start a dialogue with their provider and to explore less invasive treatment alternatives if possible. There is a $100 or $500 copayment for Additional Cost Tier procedures, plus the applicable deductible & copayment still apply (in contract benefit summaries and member handbook).	1, 2,5,6
5. Provide information so that patients and providers know price and quality data	Web portal access for members	X	X	X	Website dedicated to members with targeted communication and outreach	
	Specific Treatment Cost Navigator and Prescription pricing tool		X		Cost calculators that OEBB members can enter a procedure or prescriptions into and find out the estimated cost	2
	Plan comparison available to members		X	X	Individuals will use Cover Oregon to make meaningful comparisons of QHPs. Carriers offering QHPs through Cover Oregon will report on networks, care coordination efforts, and quality measures. Individuals can view QHP performance in these areas to help them make choices among Carriers and QHPs. OEBB has partnered with Truven Health Analytics and MIT to implement and evaluate an informed decision making enrollment tool focusing on cost. Offered at open enrollment.	
6. Maintain costs at a sustainable fixed rate of growth	2013-2015 budget	X			Caps PEBB expenditure growth Per Employee Per Month at 4.4% for 2013, 3.4% for 2014, and 3.4% for 2015	

Overlap Among 2014 Quality Measures: OHA CCO, Cover Oregon and PEBB

Measure	NQF Number	CCO[1]	Cover Oregon[2]	PEBB/OEBB[3]
MENTAL HEALTH, ALCOHOL AND DRUG USE				
Adherence to antipsychotics for individual with schizophrenia	Unspecified	X		
Alcohol and drug misuse, screening, brief intervention, and referral for treatment	Unspecified	X		X
Alcohol and drug treatment success rate	Unspecified			X
Antidepressant medication management	0105	X	X	
Follow-up after hospitalization for mental illness	0576	X		X
Follow-up care for children prescribed attention deficit hyperactivity disorder medication	0108	X		
Initiation and engagement of alcohol and other drug dependence treatment	0004	X	X	X
Penetration rate for mental health and chemical dependence treatment	Unspecified			X
Screening for clinical depression and follow-up plan	0418	X		X
PREGNANCY, CHILDREN, AND ADOLESCENTS				
Adolescent well child visits	Unspecified	X		X
Annual pediatric hemoglobin A1c testing	0060	X		
Antenatal steroids	0476	X		
Appropriate testing for children with pharyngitis	0002	X		
Childhood immunization status	0038	X		X
Cesarean rate for nulliparous singleton vertex	0471			X

Measure	NQF Number	CCO[1]	Cover Oregon[2]	PEBB/OEBB[3]
Developmental screening, first 36 months of life	1448	X		X
Elective delivery	0469	X		
Immunization for adolescents	1407	X		
Oral health screening for children under 3 years	Unspecified			X
Pediatric central-line associated bloodstream infections, neonatal and pediatric intensive care units	Unspecified	X		
Percentage of live births with low birth weight	0278, 1382	X		X
Prenatal and postpartum care: postpartum care rate	1391	X		
Prenatal and postpartum care: timeliness of prenatal care	1517	X	X	
Prevalence of early childhood carries	Unspecified			X
Child and adolescent BMI assessment	Unspecified	X		
Well-child visits, first 15 months of life	1392	X	X	
Well-child visits, 3rd, 4th, 5th, and 6th years of life	1516	X		
SCREENINGS AND PREVENTIVE CARE				
Adult BMI assessment	Unspecified	X		X
Annual HIV/AIDS medical visit	0403	X		
Annual monitoring for patients on persistent medications	0021			
Breast cancer screening	0031	X	X	X
Breast feeding exclusivity at 6 months	Unspecified			X
Cervical cancer screening	0032	X		X
Chlamydia screening in women age 21-24	0033	X		X
Colorectal cancer screening	Unspecified	X		X

Measure	NQF Number	CCO[1]	Cover Oregon[2]	PEBB/OEBB[3]
Comprehensive diabetes screening	Unspecified	X	X	X
Controlling high blood pressure	0018	X	X	X
Dental visits	Unspecified			X
Fall risk screening	Unspecified			X
Flu shots for adults ages 50-64	0039	X	X	X
Preventive service utilization	Unspecified			X
Medical assistance with smoking and tobacco cessation	0027	X		X
Total eligibles age 1-20 who received preventive dental services	Unspecified	X		
MEMBER HEALTH STATUS				
Effective contraceptive use among women who do not desire pregnancy	Unspecified	X		
Functional status improvement	Unspecified			X
Health status improvement	Unspecified			X
Member health status, adults	Unspecified	X		
Rate of obesity among CCO enrollees (state measure)	Unspecified	X		X
Rate of tobacco use among CCO enrollees	Unspecified	X		X
Skin injuries: stage 3 or 4 pressure ulcers acquired after admission to healthcare facility	Unspecified			X
HOSPITAL RELATED				
All-cause readmissions	1789	X		X
Ambulatory care: hospital admissions	See Note 3	X	X	X
Annual percentage of asthma patients age 2-20 with one or more asthma-related emergency department visit	1381	X		
Hospital acquired infection rates	Unspecified			X
Hospital process of care	Unspecified			X

Measure	NQF Number	CCO[1]	Cover Oregon[2]	PEBB/OEBB[3]
Potentially avoidable emergency department visits	Unspecified	X		X
CUSTOMER SERVICE				
Chronic disease self-management support	Unspecified			X
Customer Service: information	Unspecified	X	X	
Customer service: courtesy and respect	Unspecified	X	X	
Getting needed care and getting care quickly	Unspecified	X	X	X
Overall rating of health care	Unspecified		X	X
Primary provider or provider team	Unspecified			X
Shared decision making or participation in care planning	Unspecified			X
Wait time for dental visit	Unspecified			X
OTHER				
Advanced directives: percentage of members who have an advanced directive	Unspecified			X
Care transition: transition record transmitted to health care professional	1391	X		
Child and adolescent access to primary care practitioners	Unspecified	X		
Coordination with long term care (for example, percentage of dual eligible discharged from acute care to home or community-based settings)	Unspecified			X
Electronic health record adoption	Unspecified	X		
End-of-life care preferences	Unspecified			X
Falls: patient death or serious physical injury associated with a fall while being cared for in a healthcare facility	Unspecified			X

Measure	NQF Number	CCO[1]	Cover Oregon[2]	PEBB/OEBB[3]
Healthy eating: for example, percentage of adults and children who eat recommended number of fruit and vegetable servings	Unspecified			X
Improvement in employment status or school attendance for individuals with behavioral health diagnosis	Unspecified			X
Improvement in housing status for individuals with behavioral health diagnosis	Unspecified			X
Kindergarten readiness	Unspecified			X
Medication errors	Unspecified			X
Medication reconciliation post-discharge	0554	X		X
Mental and physical health assessment within 60 days for children in DHS custody (state measure)	Unspecified	X		
Patient-centered primary care home enrollment (state measure)	Unspecified	X		
Physical activity: percentage of adults and children who meet recommendations for physical activity	Unspecified			X
Physician Orders for Life-Sustaining Treatment (POLST) forms: percentage of members who have a POLST form on file	Unspecified			X
Physician Orders for Life-Sustaining Treatment (POLST) forms: percentage of members whose end-of-life care matches preferences in POLST registry	Unspecified			X

Measure	NQF Number	CCO[1]	Cover Oregon[2]	PEBB/OEBB[3]
Service engagement: Percentage of members who received no health services at all in a given period	Unspecified			X
Use of imaging studies for low back pain	Unspecified			X
Use of palliative or hospice care at the end of life	Unspecified			X

[1] Oregon Health Authority. January 2013. *Oregon Measurement Strategy.* Accessed January 23, 2013 from http://www.oregon.gov/oha/Documents/MeasurementStrategy.pdf

[2] Oregon Health Care Quality Corporation. October 2013. *Cover Oregon Year One Measure Specifications.*

[3] Potential CCO Performance Measures by Category, PEBB & OEBB Alignment Discussion