

Oregon Health Policy Board

AGENDA

November 8, 2011

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 am to 12:30 pm

Live web streamed at: [OHPB Live Web Streaming](#)

	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll call Consent agenda: <ul style="list-style-type: none">• 10/11/11 minutes• Alternative Healthcare Workers Committee Update	Chair, Eric Parsons	X
2	8:35	Director's Report	Bruce Goldberg	
3	8:45	Work Group Feedback – What happened in October and what's happening next: <ul style="list-style-type: none">• Coordinated Care Organization Criteria• Global Budget Methodology• Outcomes, Quality and Efficiency Metrics• Integration of care for people dually eligible for Medicare and Medicaid	Board Members Tina Edlund	
4	9:00	DRAFT Business Plan for Health Care Transformation	Diana Bianco	
	10:30	Break		
5	10:45	Invited Testimony	TBD	
6	11:30	Legislative Concept	Linda Grimms	
7	11:40	Community meetings feedback	Jeremy Vandehey	
8	12:00	Public Testimony	Chair	
9	12:30	Adjourn		

Upcoming

December 13, 2011

Market Square Building

1:00 pm to 5:00 pm

Oregon Health Policy Board
DRAFT Minutes
October 11, 2011
1:00pm – 5:00pm
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Item

Welcome and Call To Order

Vice-Chair Lillian Shirley called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except for Chair Eric Parsons, Felisa Hagins and Eileen Brady; Nita Werner joined by phone.

Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).

Consent Agenda:

Minutes from the September 13, 2011 meeting were unanimously approved.

Vice-Chair Shirley nominated Abbey Hendricks from Multnomah County to fill a vacant seat on the Public Employers Health Purchasing Committee. Passed unanimously.

Director's Report – Dr. Bruce Goldberg

Dr. Goldberg spoke about an increase in Healthy Kids enrollment; there are now more than 100,000 children enrolled in the program. He reflected on community meetings about Coordinated Care Organizations throughout the state. Dr. Goldberg gave an update on HB 3650 work groups and transformation work. He also reported that Governor John Kitzhaber gave a keynote speech about the roles states play in national health care reform at the 2011 Medicaid Managed Care Conference in Washington D.C.

The Director's Report can be found [here](#), starting on page 5. More information on the Community Meetings can be found at www.health.oregon.gov. A press release about the Governor's keynote speech can be found [here](#).

Medical Assistance Program Update – Judy Mohr Peterson presented by phone

Judy Mohr Peterson gave a progress update about the implementation of rate reductions. She also spoke about support for providers through health home subsidies and positive steps toward patient-centered care.

PEBB/OEBB Update – Joan Kapowich presented by phone

Joan Kapowich gave an update on open enrollment. She also reflected on the joint PEBB/OEBB meeting that was held on September 22, which focused on the Transformation timeline and how to incorporate CCOs.

Minutes from the joint PEBB/OEBB meeting can be found [here](#).

Work Group Feedback – Tina Edlund

Tina Edlund spoke about the Transformation work group meetings held in September:

- Coordinated Care Organization Criteria
- Global Budget Methodology
- Outcomes, Quality and Efficiency Metrics
- Integration of care for people dually eligible for Medicare and Medicaid

September work group meeting summaries can be found [here](#), starting on page 13.

Oregon Health Policy Board Product to the Legislature – Board Discussion

Tina Edlund discussed documents that were created for the Legislature:

- Coordinated Care Organizations description
- Matrix of Suggested CCO Criteria

The CCO description can be found [here](#), on pages 41-42, and the Suggested CCO Criteria Matrix can be found [here](#), starting on page 43.

Gretchen Morley spoke about the Proposed Business Plan Outline for House Bill 3650 Health Care Transformation.

The Proposed Business Plan Outline can be found [here](#), on pages 53-56.

State of Equity Report – Tricia Tillman and Julie Maher

Tricia Tillman and Julie Maher presented a State of Equity Report designed to help Oregon take another step toward remediation of health inequities. The purpose of the report is to identify disparities in services by:

- Need
- Access
- Customer service quality
- Outcomes

Tillman submitted a letter as a follow-up to the September Health Equity webinar, which includes specific strategies to advance health equity.

The State of Equity Presentation can be found [here](#), starting on page 57. Tricia Tillman's letter can be found [here](#), starting on page 81.

Public Testimony

The board heard public testimony from the following people:

- Dr. Bob Dannenhoffer, CEO, Douglas County Independent Physician Association, spoke about DCIPA's excitement about transformation and their formal plans to become a CCO. It will be important to build on what is already in place there. He also iterated his concerns over questions about the structure of CCOs in each county, the possibility for short term cost increases, and the need for flexibility that will allow innovation.
- Dr. Peter Bernardo, WVP Health Authority board member, stated that he shared the same concerns as Dr. Dannenhoffer. He spoke about how MCOs are already doing what CCOs will do.
- Dave Ford, CEO, CareOregon, talked about the structural changes that CCOs will bring, saying that this change is a deep commitment that will seriously change the health care landscape. What will the standards be? What are the targets? How will we encourage experimentation and financing innovations?
- Marion County Commissioner Janet Carlson spoke about the role of local public health and mental health authority. Carlson also spoke about county governance roles in health care.
- Cindy Becker, Director, Health, Housing, and Human Services for Clackamas County, spoke about what counties can bring to the table, specifically in mental health and addictions, community-based care and care coordination.
- Jim Russell, Executive Director, Mid Valley Behavioral Care Network, spoke about MHOs and encouraged the Board to continue moving forward.
- Joanne Fuller, Chief Operating Officer, Multnomah County, spoke about counties as stakeholders and the link between health care reform and public safety.
- John Mullin, Oregon Law Center, spoke about the processes that will affect the legal services network.
- Mike Saslow spoke about his concerns with the work groups, health information technology and

health care expertise.

- Mark Stephens, Oregon Fire Chiefs Association, spoke about EMS being proactive and creating partnerships.
- Rebecca Sandoval, home care worker, spoke about her concerns with the CHW and the future of home care workers.

Written testimony that was handed out is available on the Policy Board meetings page:

<http://health.oregon.gov/OHA/OHPB/meetings/index.shtml>

Adjourn

Next meeting:

November 8, 2011

8:00 am to 12:30 pm

Market Square Building

1515 SW 5th Ave, 9th Floor

Portland, OR 97201



OHPB Workforce Committee Non-Traditional Health Worker (NTHW) Subcommittee

Accomplishments To-Date

- Convened 26 member subcommittee comprised of non-traditional health workers, health systems, community based organization representation
- Conducted national literature review and conducted Oregon survey of NTHWs regarding scope of practice, competencies, work settings, and education and training. Received 649 responses.
- Developed tool to finalize list of core vs. optional competencies and training.
- Began discussion of certification (relative benefits and challenges of individual and training program certification)

Next Steps

- Develop final list of core competencies
- Finalize discussion of certification
- Begin identifying specific supervision requirements to meet CMS requirements
- Draft recommendations for OHPB

Areas of Agreement

- There are significant similarities in competencies, training, and scope of work across worker types.
- Being a member of the community served is key to the success of these workers.
- We need to address potential challenges in building legitimacy for these workers in health care settings. Part of the ongoing work will be to support health care providers to utilize non-traditional health workers effectively.

Areas of Tension

- **Certification of Individual**
 - Fear of losing a significant number of current non-traditional workers if individual certification requirements are too stringent and/or costly.
 - Fear of losing the essence of the work by imposing too many requirements for certification.
 - Fear of separating community member from her/his community.

- **Certification of Training***
 - Fear that anyone can receive training, but without competency testing and ongoing development, skills and knowledge may not be present.
 - Fear that people will be denied access to training programs if they don't meet "pre-requisite" skills.

*Note: By the end of the last meeting, it appeared that there was some general movement towards certifying training programs.

NTHW Timeline and Meeting Content

October 27, 2011

- Clarify CMS parameters for reimbursement
- Working consensus on:
 - Certification on training programs?
 - Certification of individual workers?
 - None of the above (recommended training or competencies only)
- Roles and competencies

November 2011

- Finalize roles/ competencies
- Supervision requirements

December 2011

- Finalize Supervision requirements
- Training and certification details

January 2012

- DRAFT recommendations

February 2012

- Legislative Session
- Public comment

**Monthly Report to
Oregon Health Policy Board
November 8, 2011**

Bruce Goldberg, M.D.

PROGRAM AND KEY ISSUE UPDATES

Healthy Kids Program

Enrollment

- Through September 2011, **101,428** more children have been enrolled into Healthy Kids for a total child enrollment of **371,501**.
- **5,935** of these children are now enrolled in Healthy KidsConnect.
- This is 127% of our goal of 80,000 more children and a 38% increase in enrollment since June 2009 (baseline).
- *See the attached chart for a more detailed look at Healthy Kids enrollment.*
- Healthy Kids has had another successful back-to-school outreach campaign this fall.

Outreach

- Healthy Kids has had another successful back-to-school outreach campaign this fall.
- The program continues to improve its efforts at reaching out to diverse communities. New materials have been designed to more effectively reach out to the Native American/American Indian community as well as the African American community. These materials were designed with direction from and the partnership of members of these communities.
- CMS has recognized the significant achievements of Oregon Healthy Kids by giving Cathy Kaufmann, Oregon Healthy Kids Administrator, a 2011 Excellence in Children's Health Outreach and Enrollment award.

OHP Standard

- The 2011/2013 biennial goal is to have an average monthly enrollment of 60,000 individuals enrolled in OHP Standard. This goal has been carried over from the 2009/2011 biennium.
- As of September 15, 2011, enrollment in OHP Standard is now **65,406**.
- There have now been twenty-one random drawings to date. The last drawing was on October 5, 2011 for 3,500 names. The next drawing will occur on November 2, 2011 for 3,500 names.

Community Meetings

The Oregon Health Policy Board and the Oregon Health Authority completed three weeks of community meetings in October, covering eight cities and crossing 1,600 miles. Altogether, more than 1,000 people showed up to learn about and discuss CCOs. The meetings were a great opportunity to talk with clients, providers, advocates, tribes, home health care workers, county representatives and others across the state and to listen to their ideas and address their concerns. The interactive meetings were also an important way to ensure that CCOs work in a local and suitable way for diverse stakeholders and communities throughout Oregon.

More to come on this topic later today, including a review of the feedback received at the meetings.

November Legislative Days

The Oregon Legislature's interim committees meet Nov. 16-18. The Oregon Health Authority will provide updates on topics including health system transformation and the health insurance exchange IT grant. Legislative interim committees will meet once more in January, prior to the 2012 February legislative session.

Upcoming

Next OHPB meeting:

December 13, 2011

1:00 PM to 4:30 PM

Market Square Building

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
9-Jul	271,493	0	271,493	3,648	3,648	5%
9-Aug	276,712	0	276,712	8,867	5,219	11%
9-Sep	281,374	0	281,374	13,529	4,662	17%
9-Oct	289,015	0	289,015	21,170	7,641	26%
9-Nov	294,459	0	294,459	26,614	5,444	33%
9-Dec	298,600	0	298,600	30,755	4,141	38%
10-Jan	303,026	0	303,026	35,181	4,426	44%
10-Feb	305,785	205	305,990	38,145	2,964	48%
10-Mar	309,047	549	309,596	41,751	3,606	52%
10-Apr	312,191	923	313,114	45,269	3,518	57%
10-May	314,933	1,133	316,066	48,221	2,952	60%
10-Jun	316,891	1,338	318,229	50,384	2,163	63%
10-Jul	319,878	1,662	321,540	53,695	3,311	67%
10-Aug	322,694	1,948	324,642	56,797	3,102	71%
10-Sep	326,545	2,335	328,880	61,035	4,238	76%
10-Oct	331,837	2,700	334,537	66,692	5,657	83%
10-Nov	334,120	3,046	337,166	69,321	2,629	87%
10-Dec	337,498	3,441	340,939	73,094	3,773	91%
11-Jan	342,272	3,712	345,984	78,139	5,045	98%
11-Feb	348,660	4,081	352,741	84,896	6,757	106%
11-Mar	349,424	4,372	353,796	85,867	971	107%
11-Apr	353,526	4,732	358,258	90,329	4,462	113%
11-May	354,070	4,970	359,040	91,111	782	114%
11-June	356,645	5,196	361,841	93,892	2,781	117%
11-July	358,990	5,419	364,409	96,432	2,540	121%
11-Aug	360,644	5,626	366,270	98,300	1,868	123%
11-Sep	363,474	5,935	369,409	101,428	3,128	127%



OHPB Delivery System Transformation Work Groups' October Meetings and Public Feedback

November 8, 2011

CCO Criteria: Governance

Question: Putting yourself in OHA's shoes, how would you evaluate a CCO's governance, given the HB3650 requirement that:

Each CCO has a governance structure that includes:

- A) A majority interest consisting of the persons that share in the financial risk of the organization;
- B) The major components of the health care delivery system; and
- C) The community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community.

CCO Criteria: Governance

Key Points for the Oregon Health Policy Board:

- Governance structure and community engagement should reflect an assessment of community needs and support the CCO's transformation goals, such as addressing health disparities and the Triple Aim goals.
- Clarification is needed on the meaning of "persons that share in the financial risk of the organization."
- The OHPB should consider a requirement that a member of the CCO Community Advisory Council sit on the CCO governing board.
- There should be transparency and accountability for the governing board's consideration and decision regarding recommendations from the Community Advisory Council.
- Care should be taken that mental health and addictions concerns are not under-represented on either the governing board or the Community Advisory Council.

CCO Criteria: Financial Solvency

Question: HB 3650 calls for the development of a proposal for financial reporting requirements for CCOs to ensure against the organization's risks of insolvency, with filing of financial reports to only one regulatory agency.

Based on the CHSC presentation and on experience in Oregon, what are the most important factors the state should consider in evaluating CCO financial solvency?

CCO Criteria: Financial Solvency

Key Points for the Oregon Health Policy Board:

- DCBS may be the most reasonable agency to align Medicare and Medicaid requirements, and eventually potential plan option for PEBB and OEBC.
 - Can each CCO report to a different agency, or does *every* CCO need to report to the same agency?
- Reinsurance and risk reserves are the most effective tools for evaluating financial solvency.
- A blend of all factors, including reinsurance, risk reserves, risk sharing with providers, and enrollment levels should be reviewed in evaluating a CCO's financial sustainability.
- It may be necessary to allow a set period of time for some CCOs to fully meet all financial solvency requirements, perhaps with additional reinsurance required during this "grace period".

CCO Criteria: Public Comments

Solvency:

- Issues specific to rural entities need to be included in solvency discussions.

Governance:

- Ensure the community is represented in CCO decision-making.
- Given that a majority interest must consist of “persons that share the financial risk of the organization,” it doesn’t really matter.

Global Budget Methodology: Risk Adjustment

Question: What are the key risk adjustment considerations for CCOs?
Should we risk adjust, and if so how?

Key Points for the Oregon Health Policy Board:

- Risk adjustment is needed
- Current CDPS system is a good starting point
- Should investigate the inclusion of pharmacy data and additional demographic factors including race, ethnicity, and primary language
- Need to avoid penalizing positive outcomes or encouraging gaming the system (e.g., upcoding)
- Need to ensure that mental health risk is properly adjusted

Global Budget Methodology: Quality Incentives

Question: How can global budget payments best incentivize CCO accountability?

Key Points for the Oregon Health Policy Board:

- Quality incentives should be used to reward good performance and protect against loss of access.
- Incentives should ultimately center on health outcomes
- Incentives will need to be introduced gradually or in stages
- Incentives could be structured to support longer term improvements in population health, potentially with a focus on children
- The state should provide incentives to CCOs, but CCOs will need to engage providers
- Non-financial incentives such as reduced reporting requirements could be provided to high-performing CCOs

Outcomes, Quality and Efficiency Metrics: Outcome of October Workgroup Meeting

- Reviewed potential measures of performance by service area, including behavioral health, oral health, primary care, inpatient, end of life care, and overall health outcomes.
 - Group still prefers outcome measures whenever possible
 - Continued support for three “buckets” of measures: core, menu (CCO-specific), and developmental
 - Need for more clarity on:
 - CCO responsibility for community-level prevention and population health, vs. the responsibilities of local government, public health departments, and the State.
 - Expectations for CCOs vs. expectations for the work of providers and practices within CCOs.

Outcomes, Quality and Efficiency Metrics: Outcome of October Workgroup Meeting

- Struggle to balance interest in outcome and transformational measures with:
 - Concerns about the feasibility of measuring outcomes and the adequacy of CCOs' HIT capacity.
 - Desire to align with other quality reporting systems (e.g. Medicare Advantage) that do not currently prioritize outcomes and transformation
 - Interest in being clear about the standard of care CCOs should provide (e.g. proactive use of data to identify “hot spots” and disparities, network capacity, patient-centered primary care home standards)

Medicare-Medicaid Integration of Care and Services: Care Coordination

Question: What would effective care coordination look like from the perspective of a beneficiary, a care giver or family member, and a provider? What key elements in a CCO proposal would demonstrate that it can effectively coordinate care?

Key Points for the Oregon Health Policy Board:

- Patient-centered, culturally appropriate care team
- Including non-traditional healthcare service providers, such as peer navigators/workers, in care coordination team
- Providing adequate workforce development, training and livable wages, particularly for non-traditional providers
- Strength-based assessment, taking into account social factors
- Individualized care plan that follows the patient and is updated over time
- IT systems for communication and information sharing

Anticipated Challenges:

- Adapting model for rural areas
- Alignment with the Patient Centered Primary Care Home (PCPCH) model to avoid duplication
- Reimbursement models should support care coordination

Medicare-Medicaid Integration of Care and Services: Transitions of Care

Question: What would effective transitional care look like from the perspective of a beneficiary, a care giver or family member, and a provider? What key elements in a CCO proposal would demonstrate that it has an effective strategy for transitional care?

Key Points for the Oregon Health Policy Board:

- Quality incentives should be used to reward good performance and protect against loss of access.
- Elements of effective care coordination contribute to effective transitions of care
- Specific assessment and plan for transitions, including responsibility for follow-up care
- Determining the appropriate setting is a key part of transition planning
- Medication reconciliation and information handoff also key elements
- Focus on end-of-life care and palliative care as part of transitions of care
- In-home assessments (particularly for older adults and those with complex medical conditions) conducted for vulnerable population as part of transition process.

Medicare-Medicaid Integration of Care and Services: Public Comments

- Effective care coordination would incorporate existing patient/provider/community resources as opposed to duplicating services for the sake of creating a CCO.
- Return to the idea of a family member – ask the patient what works best for them.
- Focus on what works for the patient.

1-Paragraph Summary of each of the October HB 3650 Transformation Workgroups

CCO Criteria – October 18th Meeting Summary

The CCO Criteria Work Group discussed governance and financial solvency at its October meeting. There was general consensus that a CCO's governing board and Community Advisory Council should be tasked and populated so as to maximize support for the CCO's objectives as an agent of health systems transformation in its service area. In particular, it was suggested that the CCO certification process should evaluate the proposed governance structure only after evaluating the CCO's assessment of community needs and health disparities, and its strategic plans for meeting the Triple Aim. Regarding financial solvency, there was consensus that the two most telling factors in gauging a CCO's financial solvency will be its risk reserves and its level and type of reinsurance, but that other factors such as risk sharing with providers and proposed enrollment levels would also be important. DCBS was identified as the single state agency most reasonable to serve as the platform for aligning Medicare and Medicaid requirements.

Next Meeting: Tuesday, Nov. 15

Location: Cherry Tree Training Center, Salem, OR

Global Budget Methodology – October 17th Meeting Summary

The global budget methodology work group discussed risk adjustment and quality incentives at its October meeting. The work group broadly agreed that both were necessary: risk adjustment is needed to pay CCOs fairly and protect against cherry picking; quality incentives are needed to reward good performance and avoid diminished access to high value health care. Work group members felt that the current risk adjustment system is a good starting point, and could be expanded upon to include pharmacy data and additional demographic factors such as race, ethnicity, primary language and income. The work group agreed that quality incentives should center on health outcomes, but that this will take time. Meanwhile, a number of options exist for gradual implementation including establishing CCOs performance baseline, beginning with a limited set of measures, transitioning from process measures to outcome measures, and slowly increasing the size of incentive payments. Several innovative ideas were discussed, for example, one break out suggested using incentive payments to support investment in longer term population health improvements while another expressed interest in non-financial incentives such as reduced reporting requirements could be provided to high-performing CCOs.

Next Meeting: Monday, Nov. 14

Location: Cherry Tree Training Center, Salem, OR

1-Paragraph Summary of each of the October HB 3650 Transformation Workgroups

Medicaid/Medicare Integration – October 19th Meeting Summary

The Medicaid/Medicare Integration Work Group members focused on care coordination and transitions of care as aspects of the CCO criteria development that are particularly relevant to individuals who are dually eligible. Susan Otter presented an updated factsheet describing the population of individuals who are dually eligible, and co-chair Judy Mohr Peterson reviewed a summary of the key criteria for CCOs included in House Bill 3650. Breakout groups focused on identifying the key elements of effective care coordination and transitions of care. Key elements of care coordination that the groups identified included patient-centered care teams, strength-based needs assessments, systems for sharing information, and individualized care plans that follow the patient over time and between settings. The groups agreed that elements of effective care coordination contributed to effective transitions of care, but that a specific assessment and plan, including medication reconciliation, was needed for a care transition. Determining the appropriate setting of care was also identified as an important part of transition planning, including early planning for end of life and palliative care.

Next Meeting: Thursday, Nov. 17

Location: Cherry Tree Training Center, Salem, OR

Outcomes, Quality, and Efficiency – October 17th Meeting Summary

At their meeting on October 17th, members of the Outcomes, Quality, and Efficiency Metrics workgroup considered potential CCO performance measures by service area: behavioral health, oral health, primary care, hospital care, end of life care, and overall health outcomes. Members also received an update from Carol Robinson, Director of the Office of Health Information Technology, on current HIT and HIE capacity in Oregon. Workgroup members expressed continued support for using outcome measures whenever possible and for organizing CCO accountability metrics into three groups: core measures uniform across all CCOs; CCO-specific measures; and test or developmental measures. However, the workgroup is struggling at times to balance its interest in transformational outcome measures with concerns about feasibility, a desire to align with federal and other payers' quality reporting requirements, and a desire to be clear about the standard of care that should be provided by CCOs.

Next Meeting: Monday, Nov. 14

Location: Clackamas Community College/Wilsonville Training Center, Wilsonville, Oregon

CCO Criteria Work Group October 18, 2011 Meeting Summary

Discussion Topics: Governance and Financial Solvency

Shannon M. McMahon, Director of Coverage and Access at the Center for Health Care Strategies (CHCS), gave a presentation on qualification criteria and standards for CCOs. The presentation described a framework of health reform in terms of state regulation, local government involvement, and community engagement for exploring considerations in CCO governance and financial solvency. Shannon identified best practice and considerations from experience in other states, including Minnesota, Colorado, New Mexico, and Maine.

Regarding governance and community engagement, key factors to consider included:

- Governing board composition
- Structure of health plans and delivery systems
- Community advisory board composition
- Scope of advisory board recommendations

Regarding financial solvency standards, key factors identified included:

- CMS requirement that Medicaid managed care organizations at-risk for hospital care meet state solvency standards
- CCOs solvency might be safeguarded through such tools as
 - Reinsurance
 - Initial net worth requirement
 - Third party liability
 - Surety/fidelity bond requirement
 - Solvency reserve/deposit requirement
 - Medical loss ratio limit
 - Covered lives threshold

The Maine Guaranteed Access Reinsurance Association was identified as an example of a state administered program for spreading the cost of high claims across participating health plans. This program covers losses above identified thresholds. CHCS will provide additional information on the Maine reinsurance program. The presentation also identified legal entity options for the CCOs such as corporation (for profit or not-for-profit), partnership, and foundation.

Key considerations identified in the presentation included:

- Determination of the type and extent of community engagement in the CCO governance structure

- Financial solvency criteria sufficiently stringent to indicate the ability of the CCO to assume risk, meet the health care needs of covered populations, and achieve sustainability
- Consideration of a tiered system for CCO qualification beyond the core competency requirements, including allowances for building risk reserves over time, as shown to be feasible through programs in Minnesota and Maine and proposed in ACA COOPS (creation of non-profit, member-run health insurers financed through federal loans and grants).

Key Input for Oregon Health Policy Board

Small group discussion provided the following input

Governance

Areas of agreement:

Governance structure and community engagement should be determined by an assessment of community needs and the CCO's transformation goals.

CCO governing board should be newly constituted and not a carry-over of a pre-existing board for an organization choosing to become a CCO.

The OHPB should consider a requirement that a member of the Community Advisory Council sit on the governing board, and vice versa.

CCOs might be either for-profit or not-for-profit as long as they meet the criteria.

There should be accountability for the governing board's consideration and adoption of Community Advisory Council policy recommendations.

Care should be taken that behavioral health concerns are not under-represented on either the governing board or the Community Advisory Council.

Areas of tension:

If a COOP model is pursued in which risk partners contribute to reserves with relationally defined levels of authority, then no clear path for full county participation absent capital to contribute to reserves.

What is meant by "a majority consisting of the persons that share in the financial risk of the organization" is open to varying interpretations. Should county governments and local public health authorities be counted in this category since they will be at risk should the CCO not prove sustainable?

How can the insurance function be aligned with health systems transformation goals?

Surprises:

Locally owned and/or domestically headquartered entities are preferable as CCO candidates.

OHA might develop different governance and community engagement criteria for not-for-profit and for-profit CCOs to address the effects of the profit motive.

An assessment should be conducted to determine the types of providers available in a CCOs service area to determine provider members of governing board, and a similar assessment to determine community-at-large perspectives needed on the board in order to reflect the root causes/social determinants of health.

CCO governing board should develop an annual plan for aligning CCO business practices/requirements with the health needs of the community, and this plan should be reviewed for its appropriateness and effectiveness by OHA. In years when the CCO shows retained earnings, a portion of those retained earnings should be used to fund a health promotion project identified by the Community Advisory Council.

“Major components of the health care delivery system” should be defined in terms of broad categories of care rather than by provider types.

The application of the *Labby Theorem* in solving the calculus of evaluating a proposed CCO governing board. To wit, the following screens should be applied, in this order:

1. What are the needs of the community, as determined by a community health risk assessment?
2. How does the CCO intend to transform the health-and-health-care system, by improving which health disparity metrics How does the proposed governance structure support this transformation work, and what composition of membership is called for by a logic model specific to the CCO
3. Does the proposed governance structure meet HB 3650 requirements? What is the CCO process for ensuring involvement by the community-at-large, at the time of certification and into the future?

Financial Solvency

Areas of agreement:

Reinsurance and risk reserves are the most effective tools for assuring financial solvency, but other factors such as risk sharing with providers and proposed enrollment levels are also important.

No standard lower than the current OHP MCO standard should be considered.

Larger CCO enrollment helps to buffer the risk of insolvency, but it is difficult to know where to set a minimum enrollment threshold.

Areas of tension:

Should financial solvency standards for CCOs be a) the same as for MCOs currently in the Oregon Health Plan as administered by OHA, b) the same as for commercial and Medicare Advantage plans as administered by DCBS, c) something different, administered by a single state agency.

How does financial solvency relate to licensure? Should there be a new licensure category for CCOs, and if so should it be through DCBS?

Surprises:

When PEBB and OEBS are brought into health systems transformation and CCOs, there needs to be a new round of discussion about financial solvency. Current discussions should be relevant to OHP membership only.

CCOs should be required to develop a blueprint for how they will use their revenues to finance health care services that meet the needs in their service area.

Quality of care should be a factor in determining financial solvency.

Additional Considerations Emerging from Discussion Groups

Should OHA consider allowing a CCO to implement with Medicaid enrollees only for a limited period, and then enroll dually eligible members? If so, what are the implications for licensure and financial solvency?

Global Budget Methodology Work Group October 17, 2011 Meeting Summary

Discussion Topics: Risk Adjustment and Quality Incentives

Ross Winkelman, Managing Director and Senior Consulting Actuary at Wakely Consulting Group, presented an overview of risk adjustment practices that could be used to recognize differences in CCOs morbidity and protect against CCOs cherry-picking healthy members and avoiding individuals with chronic diseases. He stressed that risk adjustment should be accurate, unbiased and transparent while avoiding unnecessary administrative burden. He expressed that Oregon's current risk adjustment system, Chronic Illness & Disability Payment System (CDPS), performs well when member enrollment is relatively stable.

K. John McConnell, associate professor and health economist at Oregon Health & Science University, presented on types of quality incentives that could potentially be incorporated into CCO global budgets. He emphasized the following elements in designing a quality incentive program:

- The right amount of reward payment;
- Selecting high-impact performance measures;
- Structural designs, e.g. making payment reward all high-quality care by setting up multiple thresholds (thus avoiding distorted incentives in the all-or nothing approach), rewarding improvement as well as achievement, and rewarding for each patient that receives recommended care
- Prioritizing quality improvement for underserved populations.

Prof. McConnell presented Blue Cross Blue Shield of Massachusetts's Alternative Quality Contract as an illustrative model of quality incentives.

Key Feedback for Oregon Health Policy Board

The small groups provided the following feedback

Risk Adjustment

Areas of agreement:

- Risk adjustment is needed and the current system is a good starting point.
- OHA should explore the possibility of including pharmacy data in CDPS. This may improve the sensitivity of risk adjustment systems towards mental health.
- Additional demographic factors such as race, ethnicity, language and income should be considered.

Areas of tension:

- Some work group members emphasized the potential pitfalls of risk adjustment that need to be avoided:
 - Penalizing positive outcomes (i.e., paying less to plans that improve population health) or areas with more effective delivery systems already in place.

- Encouraging CCOs to upcode or otherwise game the system rather than focus on improving health outcomes, which was perceived to be a problem with Medicare Advantage.

Surprises:

- Various work group members expressed concern as to how well the current risk adjustment system reflects the mental health status of MHO members.
- One break out group felt that while risk adjustment was important in the short term, it may be preferable to phase it out over time as we increasingly focus on population health.

Quality Incentives

Areas of agreement:

- Work group members generally agreed that quality incentives should be used to protect against loss of access and reward good performance.
- Over the long term, incentives should center around measures of health outcomes
- Some form of staging or ramp-up period is likely necessary (e.g., establishment of baseline, number of measures, type of measures, size of incentive)

Areas of tension:

- Some felt that quality incentives would need to be phased in over time because improved health outcomes take time to realize. Others expressed the importance of including incentives from the outset to ensure that poor quality services do not persist over time.
- Different work group members expressed different opinions about the appropriate size of incentives. Some emphasized that small incentives (e.g., 1%-2%) could change behavior whereas others felt that an incentive of 10% or more would be needed to properly motivate CCOs.
- One group expressed that incentives should be at the CCO level, but some members felt that providers would need to have skin in the game in order for incentives to have an effect.

Surprises:

- Another group proposed the use of incentives focusing on CCO planning and investment in the health of its population longer term, perhaps with a focus on child health. This discussion suggested that such an incentive program could support the development of CCO relationships and planning to improve community wide health.
- One break out group suggested non-financial incentives such as reduced reporting requirements could be provided to high-performing CCOs.

Small Group Discussion

1. Risk Adjustment Models: Important but Limited to Addressing Selection

Risk adjustment is necessary to protect vulnerable populations, but does not ensure quality

All groups acknowledged a role for using risk adjustment to ensure that CCOs do not avoid expensive or vulnerable populations. In addition, each group expressed interest in investigating the use of additional demographic risk adjustment factors. Each group mentioned race, ethnicity and language as possibilities; two groups also mentioned income and geographic location. Despite broad interest in risk adjustment, each group also expressed concerns that risk adjustment could in fact penalize improvements in members' health outcomes or areas of the state that have well-functioning delivery systems in place. One group noted that other measures such as quality incentives would be needed to offset any negative incentives created by risk adjustment, and that in the long run it may make sense to move away from risk adjustment altogether.

The current CDPS risk adjustment system should be used as a starting point; potentially include Rx data

Each break out group acknowledged that the current CDPS risk adjustment system was the logical starting point for CCO risk adjustment, but expressed interest in including pharmacy data or at least exploring the option to do so. Improving CDPS's sensitivity to mental health diagnoses was the primary motivation expressed for including pharmacy data. Two break out group noted that Oregon's use of CDPS compares favorably to the Medicare Advantage risk adjustment because our process does not incentivize upcoding, and one added that the recent patient centered primary care home (PCPCH) adjustment is commendable.

Concerns regarding mental health risk adjustment, weighting and implications for Rx drug use

Two of the break out groups expressed concern that mental health diagnoses would be properly risk adjusted and weighted relative to physical health diagnoses under an integrated system. While incorporating prescription data could improve how well mental health diagnoses are picked up by a risk adjustment system, it also may encourage inappropriate use or reliance on psychotropic drugs. This was a particular concern with respect to the treatment of children.

Additional topics raised

- Whether or not the risk adjustment system can properly handle churn.
- Whether or not the risk adjustment system properly accounts for the differences in rural areas.
- One group expressed a preference for a transparent risk adjustment methodology.
- One work group member proposed that risk adjustment should be based on health burden of disease rather than cost of treatment.

2. Quality Incentives:

Outcome measures should be emphasized, but this may be difficult at the outset

All three breakout groups emphasized that quality incentives should ultimately center on outcome measures that are within CCOs control. However, each group also recognized that this would be difficult to implement from the outset given that achieving improved health

outcomes takes time. For this reason, one group suggested that process measures may need to take precedence initially. Another breakout group suggested that process measurement should be minimized and instead the number of metrics and size of bonuses should start small but increase over time (e.g., 1% in year one, 2% in year two, etc.).

Opinions vary on the proper size of incentives

As mentioned, one group suggested a 1% incentive that increased by 1% point annually until it reached 5%. A member of a different breakout group suggested that incentives of at least 10% would be needed to get people's attention. Others worried about that a large incentive may be difficult given already slim margins. Other workgroup members felt that a small incentive (e.g., 1%-2%) could be large enough to change behavior, at least for some service categories (e.g., mental health). One group pointed out that the Medicare Advantage STARS program, which provides 3% bonuses, appeared to provide a large enough incentive to command attention. Finally, one group felt that progressive improvement should be rewarded with progressive bonuses.

Incentive payments should support long-term initiatives

One group agreed that if the goal is better health than at least a portion of CCO incentives should focus on CCO planning and investment in the health of its population longer term, perhaps with a focus on child health. This discussion suggested that such an incentive program could support the development of CCO relationships and planning to improve community wide health.

Reducing reporting requirements could serve as an incentive

One group mentioned that one way to incentivize quality without requiring new finances or a withhold of current finances would be to reduce the regulatory burden of CCOs that are performing well. For example, CCOs that met specific thresholds for quality incentives could submit non-essential reporting on a biennial rather than annual basis.

Additional thoughts that emerged from workgroup discussions

- Incentives should be at the CCO level, but providers will need skin in the game in order for incentives to work.
- Rewards for quality should be contingent upon reducing costs.
- Consistency of metrics across CCOs is important given that some provider groups will participate in more than one CCO.
- Some measurement systems can be very expensive to license and administer.
- There needs to be a plan of action for dealing with CCOs that fall below minimum quality standards.

Outcomes, Quality, & Efficiency Metrics Work Group

October 17, 2011 Meeting Summary

Discussion Topics

Oregon Health Policy Board members Dr. Carlos Crespo and Dr. Chuck Hofmann gave a re-cap of the September meeting, summarized feedback from the Board and members of the public, and described some relevant discussions from other HB 3650 workgroups. Workgroup members also heard a presentation from Carol Robinson, Administrator of the Office of Health Information Technology, on the current environment for EHR adoption and HIE functionality in Oregon.

The group subsequently divided into three smaller discussion groups to consider potential CCO performance measures under seven headings: overall outcomes, mental health, addictions, oral health, primary care, hospital care, and end-of-life care. Members were asked to address three questions in relation to the example measures listed (*see meeting materials*):

- Which indicators are “must-haves” for CCO accountability?
- Which indicators are not good candidates for CCO performance measures?
- What other indicators should be considered?

Key Points for the Oregon Health Policy Board

Consensus

- Workgroup members seemed to agree about the need for greater clarity on a few topics:
 - CCOs’ level of responsibility for community-level prevention and population health, vs. the responsibilities of local government, public health departments, and the State.
 - Expectations for CCOs vs. expectations for the work of providers and practices within CCOs.
- In general, there continues to be consensus about the desire to focus on outcomes (and outcome measures) and to avoid being too prescriptive about the ways in which CCOs achieve those outcomes. However, the group is struggling to balance this desire with feasibility concerns; see “tensions” below.
- There seems to be consensus that the initial list of required CCO measures should be quite small and fairly high-level. There would be room for more measures and more granularity in menu and/or developmental sets.

Tensions

- The workgroup is struggling to balance its interest in strong outcome measures and in making space for innovation at the CCO level with:
 - Concerns about the feasibility of measuring outcomes and the adequacy of CCOs' HIT capacity.
 - A desire to align with performance measures that are or will be required by CMS, NCQA, and others in order to make measurement more affordable and efficient. The difficulty here is that other measure sets may not emphasize outcomes and transformation to the same extent as the workgroup wishes to do.
 - An interest in being very clear about the standard of care that CCO must provide. For example, the October breakout group discussions generated these and other expectations for standards of care or services:
 - CCOs describe how they will proactively use data, screenings, and assessments to identify and address "hot spots" (high risk groups or patterns of high utilization) or disparities;
 - CCOs demonstrate sufficient network capacity, particularly for specialty care, and the ability to provide integrated across domains and settings
 - CCOs use patient education as a core component of prevention, particularly for cardiovascular disease and breast cancer
 - CCOs hold their primary care practices accountable to Oregon Patient-Centered Primary Care Home Standards
 - CCOs include families and service recipients in mental health treatment teams.

A careful staging strategy for CCO performance issues may help address the first two concerns. The third interest could be met by addressing the suggestions via CCO criteria rather than metrics.

Surprises

- None.

HIT and HIE Capacity Presentation

Key points from Carol Robinson's presentation included:

- Fully functional EHRs are still not common among small, private practices. Large health systems and hospitals are much more likely to be using EHRs. New Medicaid incentive program (launched on September 26th) may help.
 - Dentists are eligible but not long-term care or behavioral health providers.

- EHRs are critical components but CCOs really need HIE to be successful, to exchange information as needed for care coordination.
 - The federated model for HIE that Oregon stakeholders preferred does carry the risk for gaps or white space between systems. The pace of HIE infrastructure development has been slower than anticipated 2 years ago.
 - Direct—a secure direct email service for information exchange between providers—may help mitigate the HIE white space.
- The Health Policy Board has asked HITOC (the Health Information Technology Oversight Council) to bring them a proposal for minimum HIT capacity for CCOs.

Small Group Discussion

Note: Comments that pertain specifically to individual performance measures listed in the meeting discussion document can be found in a table following this section.

General Comments

- The core list of required measures should be very tight – the lists of potential measures for consideration are very long. Measurable, meaningful, and affordable should be the primary criteria. The set of developmental measures can be longer and more innovative.
- As we move toward measuring outcomes, OHA should be prepared to offer technical assistance to help CCOs achieve those outcomes.
- Members reiterated the importance of connecting selected CCO performance measures to the Triple Aim
- The workgroup continues to be very interested in prevention-focused measures.
- The issue of churn—members switching CCOs during a single measurement or budget period—was raised again as a complicating factor for measuring CCO performance.
- ED use may be useful as a measure of poor access and lack of prevention across a range of topic areas.
- Members noted that technical specifications will need to be adopted or developed once the initial set of measures is selected

Comments on potential overall outcomes measures

- Members in one group had some concerns about the reliability & validity of some of the patient- or member-reported indicators listed in this section.
 - To the extent that member-reported indicators are selected, they should be already included or easy to incorporate into data collection tools that systems already use, such as CAHPS

- Another group felt that the focus for overall health outcomes should be on a comprehensive measure(s) that integrates all domains: physical (primary and specialty), oral, addictions and mental health, etc.
- Tobacco, birth weight, and breastfeeding would be good candidates for prevention-focused outcome measures
- Additional outcomes measures suggested include (these are also listed in the table following this section):
 - Breastfeeding rates

*Comments on potential **mental health** measures*

- One group discussed the pros and cons of separating mental health and addictions measures, even for purposes of discussion, and advocated for combining them for two reasons: 1) to reinforce the need to break down silos; and 2) to recognize that the core things each system has to achieve are very similar.
- Some members felt that the housing, education, and employment outcome measures would be appropriate only as future or development measures, since the events were not sufficiently under the control of CCOs to include. Members did suggest that it would be reasonable for the CCO criteria to include requirements around community connections and partnerships.
 - However, others felt that it was reasonable to hold CCOs accountable for some of these outcomes, especially for Medicaid-billable services like supported employment and supported housing.
 - In addition to alignment with community services, one member suggested that CCOs also be required (via criteria or performance measure) to include families and mental health service recipients on treatment teams.
- Several members argued that basic access and screening measures—as well as engagement--were particularly important because we currently do a very poor job identifying mental health and addictions needs and keeping people in treatment.
- One group commented that the presence of an addictions or mental health-related diagnosis should be used as a stratifying factor to examine performance on other indicators, similar to reporting results by race, ethnicity, or primary language
- Additional mental health measures suggested include (these are also listed in the table following this section):
 - Initiation and engagement in services (for mental health and addictions)
 - Readmissions for mental health diagnoses (also discussed in September)
 - Admission rates for acute psychiatric and residential treatment
 - Follow-up after ER visit or inpatient hospitalization (also discussed in September)

- Utilization of lower-cost options when available (e.g. outpatient rather than inpatient treatment)
- Screening for adverse childhood events

*Comments on potential **addictions** measures*

- Several members argued that basic access and screening measures—as well as engagement--were particularly important because we currently do a very poor job identifying mental health and addictions needs and keeping people in treatment. One group noted that addictions-related costs were driven by people not in treatment.
- Additional addictions measures that were suggested include (these are also listed in the table following this section):
 - Initiation and engagement in services (for mental health and addictions)
 - Penetration rate (also discussed in September)
 - Success rate: % of individuals treated who are clean and sober X months or years later
 - % of infants born with an addiction
 - Use of peer wellness specialists among individuals receiving addictions services
 - Utilization of lower-cost options when available (e.g. outpatient rather than inpatient treatment)
 - Follow-up after ER visit or inpatient hospitalization (also discussed in September)

*Comments on potential **oral health** measures*

- More than one group noted that access was probably the primary concern within oral health and suggested that access metrics be prioritized.
 - Access measures should apply across all ages (not just children)
 - ED visits for dental conditions would be an indirect indicator of poor access
- Some members emphasized the importance of CCO criteria or expectations in the area of oral health, including:
 - Network adequacy for dental care providers;
 - Navigation assistance to access dental care
 - Appropriate referrals for chronic diseases related to oral health issues
- Additional oral health measures that were suggested include (these are also listed in the table following this section):
 - 3rd trimester dental visit

- Wait time for dental appointments
- Prevalence of caries in young children (baby bottle tooth decay), as a prevention-focused measure

*Comments on potential **hospital** measures*

- In general, members favored the hospital measures that were also part of Medicare's hospital value-based purchasing initiative, the Medicare Advantage STARS program, or were HEDIS measures. This includes readmissions, healthcare acquired conditions, and skin injuries.
- Additional hospital measures that were suggested include (these are also listed in the table following this section):
 - Influenza vaccination
 - Medication errors

*Comments on potential **primary care** measures*

- Members generally commented that there were too many potential indicators listed in this section. One group proposed that CCOs should choose among a subset of primary care focused options those measures most relevant to their populations.
- While emphasizing that outcome measures should be used as much as possible, some groups expressed concern that the outcome measures in this section (e.g. blood pressure control) would be difficult to achieve without a fully functioning EHR system and/or patient registry, or labor-intensive chart reviews.
 - However, it was noted that the ability to track members by condition and over time (via a registry, EHR, or other means) was an important component of patient-centered primary care home functioning, and that outcome measures support population health and should result in cost savings over time.
 - In general, there seemed to be support for using these kinds of measures while perhaps allowing an interim solution for CCOs without the necessary registry or HIT capacity.
- Some members had questions about the intended level of measurement because many of the indicators listed are most commonly used for provider-level measurement whereas the workgroup is focused on CCO-level accountability.
- Members felt that, as a general rule, primary care performance measures should align with US Preventive Services Task Force guidelines and should have the flexibility to change over time as national guidelines and evidence-based best practices develop.
- Additional primary care measures that were suggested include (these are also listed in the table following this section):

- Some measures of exercise and healthy eating
- Depression screening and treatment
- Access – the number or % of members who are not seeking primary care
- Breastfeeding rates (listed also under overall outcomes)
- A measure of investment in primary care (e.g. increase in % of medical spend on primary care)

*Comments on potential **end-of-life care** measures*

- Several members commented that these measures should be restricted to particular ages and/or conditions, particularly individuals eligible for both Medicaid and Medicare.
 - It was noted that members with the highest costs in the last three months of life tend to be very ill children and those who have suffered accidents. Targeting end-of-life care measures to dual eligibles will reduce noise and make them more actionable.
- Members expressed interest in more measures related to quality of end of life care, as opposed to cost or appropriateness.
- Members in one group commented that it can be difficult for health plans to know when members die; Medicaid does not supply this information.
- Additional end-of-life care measures that were suggested include (these are also listed in the table following this section):
 - Compliance with POLST

For comments on particular measures, please see the table on the following page.

Measure	Data type	Alignment *	Comments
Overall health outcomes			
Health status improvement % members reporting improvement or maintenance of: <ul style="list-style-type: none"> • Physical health • Mental health 	Patient or enrollee survey	Medicare Advantage	<ul style="list-style-type: none"> • Too “loose”
Functional status improvement % members covered by both Medicare & Medicaid who show positive change or maintenance in function (Activities of Daily Living as measured by the AM-PAC/SPD CAPS or OASIS)	Program admin data	TBD	<ul style="list-style-type: none"> • What about measuring functional status via member survey (e.g. CAHPS)?
Healthy Days Measures % members rating their health in the past month as “good” or better <ul style="list-style-type: none"> • General health • Physical health • Mental health % members reporting that poor health limited usual activities during the past month	Patient or enrollee survey	Healthy People 2020; several population health surveys (e.g. BRFSS)	<ul style="list-style-type: none"> • Too “loose”
Tobacco use prevalence % CCO enrollees (not limited to those who have had clinical visit) who use tobacco	Patient or enrollee survey	Unknown	<ul style="list-style-type: none"> • Tobacco use is important and cessation has good ROI if done well • May want to use Meaningful Use tobacco assessment measure (see primary care section) in the first few years and then phase this one in
Low birth weight Births with infant weighing less than 2,500g, as % of total	Vital records	CHIPRA	<ul style="list-style-type: none"> • Aligns well with all three elements of the triple aim and is relatively actionable in the short term

<p>Premature death / YPLL Years of potential life lost for individuals who died before age 75 (per 1,000 or other)</p>	Vital records	Healthy People 2020, others	<ul style="list-style-type: none"> • What kind of risk adjustment does this require? May not be appropriate for CCOs.
<p>Kindergarten readiness As identified by the Early Learning Council</p>	TBD	TBD	<ul style="list-style-type: none"> • Point to this structurally in CCO criteria and integrate it into practice for primary care homes but we probably don't know how to measure it well enough for July 1, 2012
<p>Breastfeeding (initiation or exclusivity at 6 months)</p>			<ul style="list-style-type: none"> • A good prevention measure
Service Area: Mental Health			
<p>Appropriate level of care (adults & children) % of individuals receiving higher-level mental health services who are at the appropriate level of care</p>	Admin data; Client assessment data	Unknown	<ul style="list-style-type: none"> • Why just for higher-level services – everyone should be at the appropriate level of care • Important, but not something to use initially • “Appropriate” could be subjective; would need to specify a standardized and reliable tool. Triangulate with some clinical indicators? • Concern that this could create a perverse incentive for CCOs to push toward scoring people based on what level of services they can afford to offer
<p>Improvement in housing status (adults) % adult mental health service recipients in need of housing upon entry to treatment who had stable housing at discharge</p>	Admin data; Patient or enrollee survey	National Outcome Measure (SAMHSA)	<ul style="list-style-type: none"> • Some debate about whether this measure would be too much outside of CCO control • Would need to be “appropriate” housing, if used

<p>Improvement in employment status (adults) % adult mental health service recipients seeking employment upon entry to treatment who had employment at discharge</p>	<p>Admin data; Patient or enrollee survey</p>	<p>National Outcome Measure (SAMHSA)</p>	<ul style="list-style-type: none"> • Some debate about whether this measure would be too much outside of CCO control
<p>Improvement in school performance (children) % children whose school performance (attendance) improved after initiation of mental health services</p>	<p>Admin data; Patient or enrollee survey</p>	<p>National Outcome Measure (SAMHSA)</p>	<ul style="list-style-type: none"> • Some debate about whether this measure would be too much outside of CCO control • One group would prioritize this as an innovation measure
<p><i>Note: September meeting also included discussion of some mental health-related indicators, namely:</i></p> <ul style="list-style-type: none"> • Follow up after hospitalization • Preventive health screening for individuals with behavioral health diagnosis / mental health screening for individuals with chronic disease • Readmission rates for inpatient psychiatric • Utilization of mental health services • Patient experience of care (several elements) • Member (patient) activation • Mental health assessment for children in DHS custody 			
<p>Initiation and engagement of addictions and mental health treatment</p>	<p>Claims/ encounter data</p>	<p>(Partial – for alcohol and drug only: HEDIS, Medicaid Adult, Meaningful Use)</p>	
<p>Penetration rate</p>			
<p>Admission rate</p> <ul style="list-style-type: none"> • Acute psychiatric care • Residential care 			
<p>Screening for adverse childhood events</p>			

Service Area: Addictions			
Service retention % individuals retained in services for at least 90 days	Admin data	National Outcome Measure (SAMHSA)	
Improvement in housing status % service recipients in need of housing upon entry to who had stable housing at discharge	Admin data; Patient or enrollee survey	National Outcome Measure (SAMHSA)	<ul style="list-style-type: none"> • Too much outside of CCO control (although some debate on this) • Would need to be “appropriate” housing, if used
Improvement in employment status % service recipients seeking employment upon entry to treatment who had employment at discharge	Admin data; Patient or enrollee survey	National Outcome Measure (SAMHSA)	<ul style="list-style-type: none"> • Too much outside of CCO control (although some debate on this)
Family stability % parents who regain custody of their children after treatment	Admin data	Unknown	<ul style="list-style-type: none"> • Too much outside of CCO control (although some debate on this)
<p><i>Note: September meeting also included discussion of some addictions-related indicators, namely:</i></p> <ul style="list-style-type: none"> • Preventive health screening for individuals with behavioral health diagnosis • Patient experience of care (several elements) • Member (patient) activation 			
% Receiving drug and alcohol treatment who are clean and sober X years later (perhaps as a future measure)			
Utilization of peer wellness specialists among people receiving chemical dependency services			
% of births where infant was born with addiction			
Use of lower-cost treatment options when available			

Improvement in penetration rate for addictions services			
Screening for alcohol misuse in primary care (e.g. SBIRT)		OR PCPCH	
Service Area: Oral health			
ED visits for dental conditions Rate of ED visits for dental conditions (per 1,000 or other)	Claims or encounter data	Unknown	<ul style="list-style-type: none"> • Good in combination with measure below • An indirect measure of poor access
Dental visits % of members aged 2-21 who had any dental visit in the past year	Claims or encounter data	HEDIS	<ul style="list-style-type: none"> • Should be all ages • Good in combination with measure above
<i>Note: September meeting also included discussion of some oral health-related indicators, namely:</i>			
<ul style="list-style-type: none"> • Access to/utilization of preventive dental services • Children's oral health screening and follow-up 			
Dental service utilization during pregnancy (e.g. third trimester visit)			
Wait time for dental appointment			
Prevalence of dental decay in young children (baby bottle tooth decay)			
Service Area: Hospital care			
Hospital processes of care[^] (CMS/TJC core measures) CCO choice of 3 among measures that meet Chassin's accountability criteria [#] e.g.: <ul style="list-style-type: none"> • AMI 8a: Primary PCI received within 90 minutes of hospital arrival • HF-3: ACEI or ARB for LVSD on discharge • PN-7 Influenza vaccination 	Largely clinical / medical record	CMS/TJC inpatient hospital quality reporting; Medicare Hospital VBP	

<p>Hospital acquired infections[^] 3 infection rates:</p> <ul style="list-style-type: none"> • CLABSI • SSI for colon surgery • SSI for abdominal hysterectomy 	<p>Clinical data via Oregon HAI program</p>	<p>(Partial) Medicare ACOs, Medicare hospital VBP</p>	
<p>Skin injuries[^] Stage 3 or 4 pressure ulcers acquired after admission to a health care facility</p>	<p>Claims/ encounter data</p>	<p>Medicare hospital VBP</p>	
<p>Falls & Trauma[^] Patient death or serious physical injury associated with a fall while being cared for in a healthcare facility</p>	<p>Claims/ encounter data</p>	<p>Medicare hospital VBP</p>	<ul style="list-style-type: none"> • Not very actionable – difficult indicator to budge
<p><i>Note: September meeting also included discussion of some hospital-related indicators, namely:</i></p> <ul style="list-style-type: none"> • Readmission rates • Care transition measure (CTM-3) • Follow up after hospitalization • Patient experience of care (several elements) • (Preventable) admissions • (Avoidable) ED use • Cesarean rate 			
<p>Influenza vaccination Pneumonia patients 50+ discharged during flu season who received flu vaccine, if not already vaccinated</p>	<p>Claims/ encounter data</p>	<p>CMS/TJC inpatient hospital quality reporting; Medicare hospital VBP</p>	
<p>Medication errors</p>			<ul style="list-style-type: none"> • Perhaps as future measure
<p>Service Area: Primary care (including prevention)</p>			
<p>Tobacco Assessment & Cessation % of enrollees age 13 and above w/visit in reporting period who were assessed for tobacco use</p>	<p>Medical record or hybrid</p>	<p>Medicaid adult; Medicare ACOs, Meaningful Use,</p>	<ul style="list-style-type: none"> • Hold CCOs responsible for outcome as well (i.e. rate of tobacco use among enrollees) • Follow-up or treatment is as important as

		OR PCPCH, QCorp	screening
<p>Weight screening and follow-up % patients with BMI documented AND, if BMI is outside parameters, a follow-up plan documented</p>	Medical record or hybrid	Medicaid adult; Medicare ACOs, Meaningful Use, HEDIS, QCorp, (OR PCPCH partial)	<ul style="list-style-type: none"> • Hold CCOs responsible for outcome as well (i.e. obesity rate among enrollees) • Follow-up or treatment is as important as screening
<p>Well child care % patients with all recommended well child visits during measurement year.</p> <ul style="list-style-type: none"> • 0-15 months • 3-6 years • 12-21 years 	Medical record or hybrid	CHIPRA, OR PCPCH, HEDIS, HKC, QCorp	<ul style="list-style-type: none"> • Well-suited to OHP population • Hold CCOs responsible for outcome as well • Follow-up or treatment is as important as screening
<p>Developmental screening % of children screened for risk of developmental, behavioral and social delays using a standardized screening tool (ASQ, MCHAT, etc) in the first three years of life</p>	Admin data or medical record	CHIPRA, OR PCPCH	<ul style="list-style-type: none"> • Well-suited to OHP population • Specify that tools should be evidence-based
<p>Childhood Immunization Status % kids up to date at 2 years (4 DtaP/DT; 3 IPV; 1 MMR; 3 influenza type B; 3 Hep B; 1 chicken pox; 4 pneumococcal conjugates).</p>	Medical record or state registry	Meaningful Use, CHIPRA, OR PCPCH, HEDIS, HKC	<ul style="list-style-type: none"> • Get feedback from state immunization advisory committee – some provider and community resistance exists • Well-suited to OHP population
<p>Chlamydia screening in women % eligible, sexually active women age with at least one Chlamydia test in past year</p>	Claims / encounter data	Meaningful Use, CHIPRA, OR PCPCH, HEDIS, HKC, QCorp	<ul style="list-style-type: none"> • Specify alignment with USPSTF guidelines
<p>Breast cancer screening % eligible women 40-69 who receive a mammogram in a two year period</p>	Claims / encounter data	Medicaid adult, Medicare ACOs, Meaningful Use, OR PCPCH, HEDIS, QCorp	<ul style="list-style-type: none"> • Specify alignment with USPSTF guidelines

<p>Cervical cancer screening % women 18-64 years of age who received one or more Pap tests during last 3 years</p>	<p>Claims / encounter data</p>	<p>Medicaid adult, Meaningful Use, OR PCPCH, HEDIS, QCorp</p>	<ul style="list-style-type: none"> Specify alignment with USPSTF guidelines
<p>Colorectal cancer screening % enrollees age 50-80 who have received appropriate colorectal cancer screening</p>	<p>Claims / encounter data</p>	<p>Medicare ACOs, Meaningful Use, OR PCPCH, HEDIS</p>	<ul style="list-style-type: none"> Specify alignment with USPSTF guidelines Not well targeted to OHP population; negative cost impact However, screening rates are low
<p>HIV testing % of members age 13-65 screened at least once for HIV, regardless of risk</p>	<p>Medical record or claims/encounter data</p>	<p>CDC</p>	<ul style="list-style-type: none"> Not beneficial or cost-effective at CCO level
<p>Controlling High Blood Pressure % hypertensives age 18–85 years with BP controlled (<140/90)</p>	<p>Medical record</p>	<p>Medicaid adult, Medicare ACOs, Meaningful Use, OR PCPCH, HEDIS</p>	<ul style="list-style-type: none"> This is still an intermediate measure – ultimate measure is prevention of complications associated with this condition.
<p>Controlling Cholesterol % individuals with coronary artery disease with lipids controlled (<100 ml/dl)</p>	<p>Medical record</p>	<p>Medicare ACOs, QCorp, (OR PCPCH partial)</p>	<ul style="list-style-type: none"> This is still an intermediate measure – ultimate measure is prevention of complications associated with this condition.
<p>Controlling Blood Sugar % diabetics (type 1 and 2) age 18 - 75 years with HbA1c under control (<8.0%)</p>	<p>Medical record</p>	<p>Medicare ACOs, Meaningful Use, OR PCPCH</p>	<ul style="list-style-type: none"> One group suggested a different standard for controlled glucose. This is still an intermediate measure – ultimate measure is prevention of complications associated with this condition.
<p>Preventable Hospital Admissions (AHRQ PQIs) Perhaps a subset of the 16 measures? E.g. 01: Diabetes short-term complications 05: Chronic Obstructive Pulmonary Disease (COPD) 07: CHF (Chronic Heart Failure) 11: Bacterial pneumonia 12: UTI (Urinary tract infection) 15: Adult asthma</p>	<p>Claims / encounter data</p>	<p>Medicaid adult, Medicare ACOs</p>	<ul style="list-style-type: none"> CCOs should have sufficient enrollment to produce valid rates. One group considered this a particularly good Primary Care measure One group member commented that total hospital admissions may adequately capture this

<p><i>Note: September meeting also included discussion of some primary care indicators, namely:</i></p> <ul style="list-style-type: none"> • <i>Use of patient-centered medical homes</i> • <i>Preventive health screening for individuals with behavioral health diagnosis / mental health screening for individuals with chronic disease</i> • <i>Patient experience of care (several elements)</i> • <i>(Preventable) admissions</i> • <i>(Avoidable) ED use</i> • <i>Follow up after hospitalization</i> • <i>Medication reconciliation</i> 			
<p>Depression screening in primary care</p>			
<p>Primary care access % members seeking primary care services</p>			
<p>Healthy eating</p>			
<p>Rate of exercise or physical activity</p>			
<p>Breastfeeding rates (listed also under overall outcomes)</p>			
<p>Measure of investment in primary care (e.g. increase in % of medical spend on primary care over time)</p>		<p>Rhode Island</p>	
<p>Service Area: End of Life Care</p>			

<p>POLST forms % members who have a POLST form completed in the registry</p>	<p>Admin data</p>		<ul style="list-style-type: none"> • Restrict to dual eligibles or some other relevant age or condition-specific group • Add “at the time of death” to achieve more specification
<p>Advanced Directives % members who have an advanced directive</p>	<p>Admin data</p>		<ul style="list-style-type: none"> • Would need a rational age cut-off for this – it’s not relevant for all adults • Add “at the time of death” to achieve more specification
<p>Location at death % of deaths occurring at home/residence, in nursing home, and in hospital</p>	<p>Clinical data or vital records</p>		<ul style="list-style-type: none"> • Too many assumptions – probably not appropriate as a performance measure
<p>Use of palliative care % of members who receive palliative care at the end of life</p>	<p>Claims/ encounter data or medical record</p>		<ul style="list-style-type: none"> • Would need a good definition of palliative in this case, which should include hospice • Goal would not be 100% - perhaps improvement?
<p>% of members for whom end-of-life care complies with POLST</p>			

DRAFT

**Medicare – Medicaid Integration of Care and Services Work Group
October 19, 2011 Meeting Summary**

Discussion Topics

Medicare-Medicaid Plans Workgroup

Co-Chair Judy Mohr Peterson updated the group on the meeting of a workgroup of Medicare and Medicaid plans. The meeting focused on better aligning the Medicare and Medicaid requirements for plans, and the group identified four key areas for focus: consolidating and improving written materials; enrollment and disenrollment issues and processes; Special Needs Plans (SNP) model of care requirements; and alignment of reporting on performance metrics.

Fact Sheet on Medicare and Medicaid Services for Individuals who are Dually Eligible

Susan Otter presented an updated fact sheet related to the population of individuals in Oregon who are dually eligible for Medicare and Medicaid services. The fact sheet included new information on the age distribution of this group, rates of chronic conditions and behavioral health conditions, and long term care expenditures associated with this population. Workgroup members provided feedback on data presentation and suggestions for additional data that would be useful to analyze.

Introduction to CCO Criteria

Co-Chair Judy Mohr Peterson reviewed a summary of the key criteria for CCOs that were included in House Bill 3650. She noted that language relevant to care coordination is woven throughout the bill. She discussed how in thinking about how to develop the criteria for CCOs it is important to find a balance between being prescriptive and allowing for innovation. She suggested that the final criteria need to establish some parameters or sideboards, but that within those parameters it may be preferable to provide a range of possible options or ask CCOs how they will meet the requirement.

Breakout Groups

The work group was divided into three smaller discussion groups to address the following questions and to identify the key points to go forward to the Oregon Health Policy Board:

- What would effective care coordination look like from the perspective of a beneficiary, a care giver or family member, and a provider? What key elements in a CCO proposal would demonstrate that it can effectively coordinate care?
- What would effective transitions of care look like from the perspective of a beneficiary, a care giver or family member, and a provider? What key elements in a CCO proposal would demonstrate that it has an effective strategy for transitions of care?

Key Points for Oregon Health Policy Board – Care Coordination and Transitions of Care

Care Coordination

Areas of Agreement:

- Need for a patient-centered, culturally appropriate care team that incorporates patient and caregivers.
- Inclusion/use of non-**traditional providers, such as peer navigators/workers, in care coordination team.**
- Providing adequate workforce development, training and livable wages, particularly for non-traditional providers.
- Utilization of a strength-based assessment, taking into account social factors (such as social determinants of health, caregiver and family supports, home environment, etc).
- Development of an individualized care plan that follows the patient and is updated over time.
- Need for holistic, system-wide communication and information sharing, including IT systems and information exchange.

Areas of Tension/Anticipated Challenges:

- Need to ensure care coordination model can work in rural areas, where there may not be as many providers to make up a team – may need to look different in different areas.
- Alignment with the Patient Centered Primary Care Home (PCPCH) model and ensuring that efforts are not duplicated.
- Payment alignment to support care coordination and ensure that providers are reimbursed appropriately to support these efforts.
- Revisited importance of metrics and ensuring accountability at CCO level.
- Theme of patient inclusion and personal responsibility
- Providers not used to coordination with government agencies.
- Need for regulatory consistency, including a single governance process

Surprises:

- None.

Transitions of Care

Areas of Agreement:

- Elements of effective care coordination will contribute to effective transitions of care.
- Need a specific assessment and plan for transitions, including who is responsible for follow-up care.
- Determining the appropriate setting is a key part of transition planning.
- Medication reconciliation and information handoff are also key elements.

Areas of Tension/Anticipated Challenges:

- How to ensure effective hand off of baton.

Surprises:

- Focus on end-of-life care and palliative care as part of transitions of care.

Small Group Discussion

What would effective care coordination look like/what are key elements?

Breakout group members discussed the key elements of effective care coordination. There was substantial agreement both within the groups and between the groups as to what these key elements were.

The groups agreed that a key element of care coordination was an interdisciplinary/multidisciplinary care team (IDT/MDT).

- Care teams need to provide person-centered, culturally specific care, with patients engaged in the process.
- Care teams may need to extend beyond traditional medical practitioners to include other key members from social services, caregivers, home care workers, and peer navigators/workers.
- A care coordinator was identified as a key member of the team who would take the lead on day-to-day coordination activities; one team also identified the need for a more advanced care manager to handle clinical tasks such as medication reconciliation and drug/treatment interactions across specialists.
- Adequate training, standards and pay are important, particularly for non-traditional providers and for the new role of care coordinator.
- Concept of care team should be flexible, who is on the team/how many members may vary depending on intensity of client needs, and availability of providers (eg, care team may be more limited in rural areas).

A standardized needs assessment was also identified as a key element.

- The assessment should be strength/ability-based, to focus on how to build on a client's strengths, and should include a focus on prevention (e.g. fall prevention).
- The assessment should be done from the person's point of view and help to identify their goals.
- The assessment needs to look at social determinants of health, not just medical determinants.

The groups identified an individualized care plan as a key tool resulting from the assessment to be used by the care team.

- The care plan needs to move with the client between different settings of care, and document the transitions that have occurred.
- The care plan should be updated as the client's condition changes.
- The care plan should incorporate after-hours needs and should plan for urgent care to be delivered in a non-hospital setting.

- One group suggested that the client should sign off on the care plan to ensure that it reflects their needs and goals.
- The SNP model of care was mentioned as an existing model including this kind of individualized care plan.

The need for holistic system-wide communication emerged as a key element and a challenge.

- The need for health information technology (HIT)/health information exchange (HIE) systems was discussed in several groups.
- One group also raised serious doubts about whether the needed HIT/HIE solutions would be possible to implement given the divergent systems that had already been adopted.
- There were several examples raised of how this is a key element lacking today, such as a nursing facility that will send after hours faxes about urgent health issues.

Payment alignment and whether providers would be reimbursed for care coordination activities was raised as a significant concern.

- This was particularly a concern for providers, who felt that some of these care coordination activities do not take place now because they are not reimbursed.
- CCO proposals would need to account for how these new care coordination activities will be paid for.

Other discussion points included:

- At the heart, effective care coordination relies on a trusted relationship.
- Care coordination with governmental entities outside the CCO (such as local mental health authority) will pose particular challenges and needs to be specifically considered/addressed.
- The care coordination work needs to be closely aligned with the Patient Centered Primary Care Home (PCPCH) model, since many of the elements are similar and there is a potential for duplicative efforts.
- Need for metrics to assess this work, including patient satisfaction; should consider existing best-practices and metrics that have already been developed, such as by NCQA.
- Ensuring patient responsibility and how to serve difficult to serve clients are both challenges that need to be addressed.
- Particular ideas around pharmacy – system to track and analyze medication non-adherence, implementation of collaborative drug therapy program giving pharmacists a greater role.
- Ensure accountability of CCOs through regulatory alignment, including a single grievance process.

What would effective transitions of care look like/what are key elements?

Breakout group members discussed the key elements of effective transitions of care. There was again substantial agreement both within the groups and between the groups.

Effective care coordination elements previously identified were seen as integral to effective transitions of care, including:

- Systems to share necessary information, including test results and care plans among other information;
- A care plan that moves with the patient, gets updated at transitions and with changes in patient condition; and
- A care coordinator who ensures a smooth hand off.

The groups also discussed the need for a specific assessment and plan to be developed for the transition of care.

- The assessment should address risks, access to care, and need for DME specific to the new setting (such as a patient returning home after an acute stay).
- The plan needs to identify needed follow-up care, and who is responsible for delivering it.
- The assessment and resulting plan should again address social determinants of health and should be patient-centered.

One group discussed the concept that an important part of transitions of care is determining the appropriate setting for a patient.

- Determining the appropriate setting will depend on the patient's needs, desires and goals, and should consider social factors (for example, availability of social supports and caregivers) in addition to medical factors.
- Transitions of care should include both transitions from a higher level of care to a lower level of care/home, and early intervention to address the increasing needs of people as their illness progresses, requiring them to move to higher levels of care.
- As such, end-of life planning (such as POLST forms) and planning for palliative care is often a critical element of transitions of care and is best when discussed early.

Other elements that were noted as critical to transitions of care included:

- Medication reconciliation/medication management;
- Role of in-home care worker; and
- The need for a true hand off (or "passing the baton") where one care setting doesn't let go of the patient until the next has really received them and is addressing their needs.

November 8, 2011

To: Oregon Health Policy Board Members
From: Tina Edlund
RE: Business Plan Questions for OHPB.

For item 4 on the Oregon Health Policy Board Nov. 8 agenda, Diana Bianco will be facilitating a Board discussion around Governance, Health Equity and Global Budget. Diana will be framing the discussion around the following questions:

Note: please refer to pages 10 to 12 in the attached DRAFT Business Plan document, for the Governance discussion, pages 7 to 8 for the Health Equity discussion, and pages 12 to 13 for the Global Budget discussion.

Governance

1. Should CCO criteria specify, beyond the statutory requirement for representation of the community at large, that the CCO governing board include consumer representation?
2. Statute requires the each CCO form a community advisory council (CAC), and there was stakeholder discussion of whether the CAC chair should be integrated into CCO governance. What does the Board believe this role should be?
3. Statute requires that the majority interest on the CCO governing board consist of persons sharing in the financial risk. Does the Board see an advantage in greater specificity in the CCO criteria regarding board composition?

Health Equity

1. There was stakeholder agreement that each CCO be required to design and perform a community health disparities assessment. If this is done, how specific should the CCO criteria be regarding this assessment and the CCO's strategic approach for reducing health disparities?
2. Are there particular aspects of health disparities that the OHA should focus on in its review of the CCO strategic approach and its effectiveness?

Global Budget Methodology

Issue:

- What Medicaid program and funds should be paid through the CCO global budgets?

Considerations:

- Enabling greater care coordination
- Reducing incentives to cost shift

- Maintaining delivery system infrastructure through transition
- Maintaining non-Medicaid funding streams and leverage
- Acknowledging that different CCOs will have different capacities and relationships in place to provide services.

Workgroup feedback:

- CCOs should be as inclusive as possible
- Include the funding if it furthers the goals of health transformation
- Need to prioritize bringing in programs that have larger utilization and budgets to get increased economies of scale.
- Inclusion of some services may need to be phased in
- Address the tradeoff between CCO flexibility and consistency, which has implications for clients and administrative burden

Question:

- What principles and priorities should govern what Medicaid programs and funding will be included in the CCO global budgets?

**Proposed Business Plan Outline: House Bill 3650 Health Care Transformation
11/8/2011 DRAFT**

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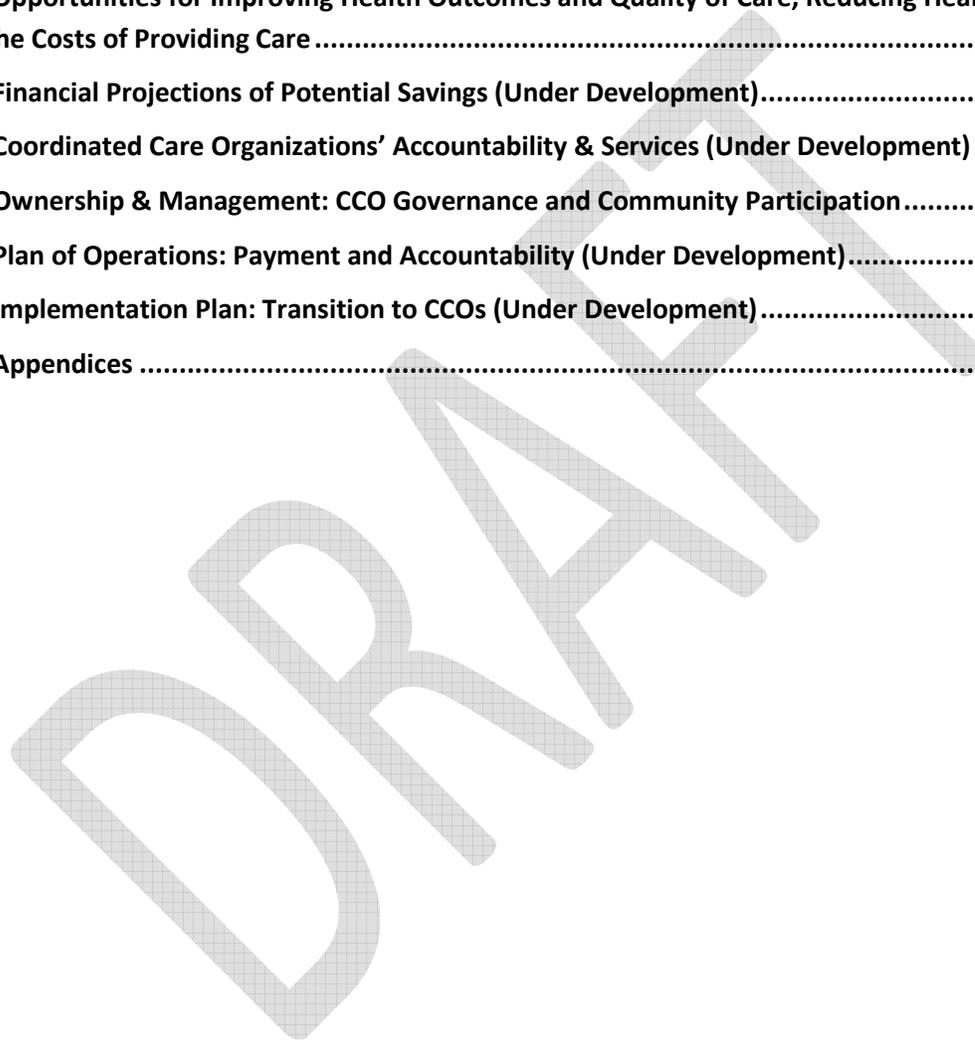
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1. Executive Summary

2. Existing Market Environment and Industry Analysis

- a. Medicaid programs, populations, and delivery systems
 - i. Programs, Services, Benefits
 - ii. Populations Covered
 1. Medicaid/CHIP
 2. Individuals who are dually eligible
 - iii. Delivery Systems
 1. Fully Capitated Health Plans (FCHPs)
 2. Physician Care Organizations (PCOs)
 3. Mental Health Organizations (MHOs)
 4. Dental Care Organizations (DCO)
 5. Primary Care Case Management (PCCM)
 6. Fee-for-service (FFS)
 - iv. Community-Based Addictions and Mental Health Supports and Services
 - v. Long term care and community supports and services
 - vi. Case management and other targeted Medicaid programs

3. Opportunities for Improving Health Outcomes and Quality of Care, Reducing Health Disparities and the Costs of Providing Care

- a. Better coordination of physical, mental and oral health for the following beneficiary groups
 - i. Temporary Assistance for Needy Families (TANF)
 - ii. Children's Health Insurance Program (CHIP)
 - iii. Poverty Level Medical (PLM) Assistance
 - iv. Aid to the Blind & Disabled
 - v. Old Age Assistance
 - vi. Foster Care, Substitute or Adoptive Care Children
 - vii. OHP Standard
 - viii. Individuals who are dually eligible for Medicare and Medicaid
- b. Better coordination of medical care with long term care, resulting in reduced hospital and ER utilization among long term care clients.
- c. Improved use of health information technology
- d. Reduced regulatory conflicts between Medicare and Medicaid
 - i. Address misaligned processes

- ii. Increase the incentive for Medicaid providers to invest in the health care of individuals who will soon become eligible for Medicare
- e. Intended effects
 - i. Patient-Centered Primary Care Homes (PCPCHs) coordinate patients' care and help ensure proper follow up to tests and procedures.
 - ii. Less duplicative or unnecessary care
 - iii. Decreased administrative costs
 - iv. Fewer avoidable medical errors
 - v. Investments in prevention to bend the cost curve and reduce the need for acute health care services
- f. Alignment with the Public Employees' Benefit Board (PEBB) and Oregon Educators Benefit Board (OEBB)
 - i. CCOs as a platform for future PEBB/OEBB options
 - ii. PEBB/OEBB transformation planning

4. Financial Projections of Potential Savings (Under Development)

- a. Historical and projected Medicaid utilization and spending by eligibility group and category of service
- b. Projection of potential savings from comparing Oregon spending and utilization to national benchmarks

5. Coordinated Care Organizations' Accountability & Services (Under Development)

- a. CCO definition and service offering

Definition: Coordinated Care Organizations (CCOs) are primary agents of health system transformation. They will be responsible for integrated and coordinated health care for physical, oral, and addictions and mental health services—with a focus on prevention and improving health equity. CCOs' delivery systems will emphasize patient-centered primary care homes, evidence-based practices, and health information technology to increase the delivery of appropriate preventive services to improve health and health care for eligible members, managed within a global budget. CCOs provision of care should promote efficiency and quality improvements in an effort to reduce year-over-year cost increases while supporting the development of local accountability for the health of the members it serves.

Services:

- i. Integrated person-centered care and services designed to provide choice, independence and dignity, emphasizing patient-centered primary care homes and individualized care plans.

- ii. Care teams responsible for comprehensive care management and service delivery with a holistic approach to addressing the supportive and therapeutic needs of each member.
- iii. Comprehensive transitional care, including appropriate follow-up, when entering and leaving an acute care facility or a long term care setting.
- iv. Prioritization of members with high risk health care needs, multiple chronic conditions, mental illness or addictions disorders in managing appropriate preventive, health, remedial and supportive care and services.
- v. Support to members in navigating the delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, community health workers, personal health navigators and similar professionals.
- vi. Support for health information technology to link services across the continuum of care.
- vii. Community Advisory Council, inclusive of members, to ensure that the health care needs of the members and the community are being addressed.
- viii. Culturally appropriate care and service delivery that helps to reduce health disparities.
- ix. Collaborative engagement with the community and with state and local governments to address the drivers of poor health.
- x. Coordination of Medicare and Medicaid services to members who are dually eligible.

Oregon is developing a demonstration proposal to the Centers for Medicare and Medicaid Services (CMS) in order for Medicare and Medicaid benefits to be aligned and integrated to the greatest extent possible for individuals who are eligible for both programs. As part of this demonstration proposal process, CMS will need to review and approve a number of elements of the overall CCO plan as they will pertain to beneficiaries, including the model of care, performance metrics, financial solvency criteria, and other aspects of the plan. In addition, the state and CCOs will work with CMS's Center for Medicare and Medicaid Innovation to establish a ground-breaking three-way contract to blend funding for services to individuals who are dually eligible, as described later in this document.

- b. CCO functional responsibilities
 - i. Organizational Information

1. Corporate status, where incorporated, affiliated corporate entity or entities involved under potential CCO contract, current Department of Consumer and Business Services (DCBS) licensure/certification
 2. Current OHA MCO contractor status, organizational changes involved in CCO application, whether CCO is formed through MCO partnership, and MCO service area vs. CCO service area
 3. Other state contracts
 - a. Oregon Medical Insurance Pool (OMIP)
 - b. Healthy Kids
 - c. PEBB
 - d. OEBS
 4. CMS contracts to provide Medicare services
 5. Administrative or other management contracts
- ii. Financial Information
1. Tangible net equity
 2. Total enrollment (proposed)
 3. Risk reserves, current and scheduled based on enrollment and projected utilization
 4. Risk management measures
 5. Delegated Risk
 6. Reinsurance and Stop Loss (if applicable and not provided through the state)
 7. Financial management system/capabilities
 - a. Incurred but not reported (IBNR) tracking
 - b. Claims payment
 - c. All payer/all claims participation – systems in place for capturing race, ethnicity, and language data
 - d. Financial performance monitoring
 8. Administrative cost allocation across books of business (Medicare Advantage, commercial)
- iii. CCO Budget Management
1. Revenue projections based on enrollment “ramp-up”

2. Expenditure projections, based on estimated utilization and costs per unit of service, including impact of alternative payment methodologies
3. Resource allocation estimates for key health systems transformation (HST) categories of service and provider type, e.g.
 - a. Primary care
 - i. Primary care for preventive services or screenings
 - ii. Primary care for acute treatment
 - b. Care coordination services including but not limited to:
 - i. Admission and discharge planning
 - ii. Ongoing care management
 - iii. Other care coordination services
 - c. Specialty care
 - d. Hospital inpatient
 - e. Diagnostics/imaging
 - f. Palliative care/hospice
 - g. Mental health and addictions services and supports
 - h. Prescription drugs
 - i. Oral health
 - j. Family planning
 - k. Community-based preventive health services
 - iv. Alternative Payment Methodologies
 1. Statutory requirements
 - a. Non-type A/B hospital payment using Medicare-like bundled payment methodologies
 - b. No payment for health-care-acquired conditions for which Medicare would refuse payment
 2. Guidelines
 - a. Standardization and best practices
 - b. Payment methodologies reimbursing on quality of care and outcomes rather than services provided
 - vi. Delivery System/Provider Network and Care Coordination
 1. Provider Network description including the following:
 - a. Community health workers

- b. Personal health navigators
 - c. Peer wellness specialists
 - d. Similar professionals
2. Management functions and support to the Delivery System/Provider Network of the CCO

v. Health Promotion and Prevention **(Under Development)**

vi. Health Equity

Health equity means reaching the highest possible level of health for all people. Health inequities are a result of health, economic, and social policies that have disadvantaged communities of color, immigrants and refugees, those with disabilities, and other diverse groups over generations. These disadvantages result in tragic health consequences for diverse groups and increased health care costs for everyone. CCOs must ensure that everyone is valued equally and health improvement strategies are tailored to meet individual needs of all members. Health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, access issues in rural areas, areas with high rates of uninsurance, or other factors should be identified. Specifically, CCOs will provide the following:

1. CCO community needs assessment of health equity issues and health disparities in its service area (CCO applicant and its community partners will develop and present a thorough assessment of the CCO's proposed service areas).
2. CCO approach and strategies for addressing health disparities and achieving health equity objectives
 - a. CCO governance and community engagement will be key elements in any successful approach to addressing health equity issues and reducing health disparities.
 - b. CCOs need concrete goals and clearly defined working partnerships to address disparities, including social and support services. Periodic analysis (qualitative and quantitative) will be needed in evaluating effectiveness.
 - c. Health equity metrics should address both health outcomes and cost impacts.

- d. The following standards may be used in evaluating the CCO's approach and strategies for addressing health disparities:
- i. Whether or not the CCO has done an assessment for organizational cultural competence.
 - ii. What key leadership will be assigned to support and monitor progress toward health equity.
 - iii. What the number of staff training hours is focused on health equity and cultural competence (race / ethnicity / sexual orientation / disability, etc.)
 - iv. Whether the CCO's hiring and training practices support effective reduction of health disparities.
 - v. Whether or not the CCO has budgeted for health equity efforts.
 - vi. Over time, CCOs should make substantial progress in addressing disparities relating to the social determinants of health. This may include determining
 1. How social determinants of health in the community are assessed.
 2. Which avoidable health gaps (health disparities) exist in the member population and should be prioritized for tracking.
 3. How resources (staff time, training, funding) are invested to eliminate disparities associated with social determinates of health?
 4. Organizational capacity of partner or contracted organizations.
 - vii. Wellness Leadership **(Under Development)**
 - viii. Health Information Technology (HIT)/Health Information Exchange (HIE) **(Under Development)**

Oregon will need to specify criteria for CCOs to participate as effective partners in health system transformation. In order to ensure successful coordinated care by enabling the availability of electronic information to all participants in coordinated care, CCOs will need to develop the capabilities described below.

1. EHRs – CCOs must facilitate providers’ adoption and meaningful use of EHRs.
 - a. Identify EHR adoption rates, may be divided by provider type and/or geographic region.
 - b. Identify strategies to increase adoption rates of certified EHRs
 - c. Minimum requirements for adoption rates will be considered by the body governing CCOs over time
2. HIE – CCOs must facilitate electronic health information exchange (HIE).
 - a. Every provider in a CCO must be registered with a Direct-enabled Health Information Service Provider (HISP) (statewide or local) or be a member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system to be able to share electronic information with any other provider within a CCO network
 - b. Minimum requirements for HIE, including rates of e-prescribing and electronic lab orders will be considered by the body governing CCOs over time.
3. Analytics – CCOs should have the technical systems and staffing capacity (either in-house or through a contract) to use patient-level data to assess provider performance, effectiveness and cost-efficiency of treatment, etc.
 - a. Report current capacity
 - b. Identify goals to use analytics to improve care coordination
 - c. Identify plans to achieve goals
4. Quality Reporting – CCOs should have the technical systems and staffing capacity necessary to report the data on quality of care that will allow the OHA to monitor the performance of the CCO.
 - a. Report current capacity to submit claims data electronically
 - b. Identify capacity and plans to collect and submit clinical data
 - c. Identify capacities and plans to collect and submit data on demographics and patient satisfaction

5. Patient Engagement – CCOs should ensure that patients and especially vulnerable and diverse populations have adequate access to IT tools to participate in their own coordinated care.
 - a. Identify opportunities for increased HIT use with current system capacity
 - b. Enhance other patient engagement efforts with HIT
6. Other HIT Applications – CCOs should identify current and future needs for HIT/HIE to facilitate effective care delivery and to coordinate care, such as telehealth, telemedicine, patient applications for smart phones and other mobile devices, etc.
 - a. Identify service areas that could be enhanced through greater HIT use
 - b. Develop a plan for increased HIT including benchmarks

6. Ownership & Management: CCO Governance and Community Participation

- a. The governance structure should be grounded in an assessment of community health needs and the CCO's transformation goals to meet those needs.
- b. In applying to be a CCO, applicants should answer the questions below in the following sequence:
 - i. *What are the priority needs of the community? How does the CCO plan to transform the health and health care system in their community? From the needs assessment, what accountability measures (e.g., metrics) will this transformation effort improve?*
 1. CCOs need to meaningfully and systematically engage the critical populations (members and community leaders/representatives) within their community to create a plan for addressing the community's needs, including health equity and health disparities, by using existing baseline data, setting goals and conducting analyses (both qualitative and quantitative) on an ongoing basis. All CCO strategies to transform the health systems in its service area should promote the Triple Aim, and should address robust coordination of care through patient-centered primary care homes, alignment of incentives for improved outcomes and increased efficiencies, and alternative payment methodologies. Goals and measures should be tied to both core and menu quality measures established by OHA.
 - ii. *How does the organization's governance structure support this transformation work today and into the future? What membership is*

important to achieve what the CCO is trying to do? How will the Community Advisory Council and the Clinical Advisory Panel support and augment the effectiveness of Board decision-making?

1. Governing Board

a. Each CCO shall have a Governing Board including

- i. A majority interest consisting of the persons that share in the financial risk of the organization—both directly through ownership or indirectly (e.g., county government or other community agency responsibility for unmet needs)—and equal parts of:
 1. The major components of the health care delivery system;
 2. The community at large, to ensure that the organization’s decision-making is consistent with the values of the members and the community; and
 3. At least one member from the Community Advisory Council (chair or co-chairs) should also serve on the Board.

2. Community Advisory Council

a. Each CCO shall convene a Community Advisory Council (CAC) that includes representatives of the community and of county government, but with consumers making up a majority of the membership, and that meets regularly to ensure that the health needs of individuals and the values of the community are being addressed.

- i. Establish structures to support meaningful engagement and participation of members, and to address barriers to participating
- ii. Community Advisory Councils must have a clear role, with assurances that recommendations to the CCO governing board are fully considered and the Community Advisory Council is informed of actions taken or deferred.

3. A CCO Clinical Advisory Panel (CAP) component may be considered as a means of assuring best clinical practices.

- a. If a Clinical Advisory Panel is established, representation on the Board could be required, similar to the Community

Advisory Council, and should assume member representation under the major components of the health care delivery system.

4. Partnerships

- a. CCOs will need to partner with local organizations in order to successfully understand and address health equity issues, mental health and addictions disorders, and other health-related needs and opportunities specific to the community. More specifically, CCOs should clearly specify their commitment to their partners and vice versa.

7. Plan of Operations: Payment and Accountability (Under Development)

- a. *Global Budget Methodology*: The CCO global budget methodology is intended to provide both incentives and flexibilities that encourage CCOs to provide high-value care, generate synergies across programs and reduce inefficient spending. CCO level risk adjustment will help to ensure that CCOs fully embrace patients with complex needs, who may benefit the most from coordinated care. Introducing quality incentives can help ensure CCO members maintain access to the care they need and encourage measurable improvements in health outcomes. CCOs will play an important role in developing global budget amounts that incorporate improved efficiencies in care delivery.
 - i. Program Inclusion and Alignment:

Definition of programs and funding to be included in global budgets and flexibilities in individual CCO budgets.

 - 1. Minimum program inclusion for all CCOs
 - a. Initial global budget
 - i. Current MCO & MHO contracted services
 - ii. Non-emergent transport
 - b. Subsequent years
 - 2. Provisional inclusion of all other title XIX and XXI funded programs within the community. *Staff working through options*: CCOs could provide a plan for providing program services or expressly opt-out for a specific period of time (state provides full list of programs as reference). This approach acknowledges differences in CCOs' relationships with program stakeholders and need for new partnerships to be formed.
 - 3. Staff are investigating whether some statewide programs not currently provided by MCOs or MHOs, such as residential mental

health services, should be included in CCO global budgets once CCOs are in place across the state. In this case, a single accountability arrangement can apply to all CCOs for providing and coordinating these services.

4. Staff are developing options around shared accountability, risk sharing, or other arrangement for financial alignment with long term care; will be the topic of November Medicare-Medicaid integration external workgroup. Staff are also considering alignment models for other services such as mental health drugs and admissions to and discharges from the state hospital.
- ii. Risk Adjustment and Risk Sharing
Method for adjusting global budgets based on member risk profiles and opportunities for CCOs to share risk with the state.
 1. Start with current Chronic Illness and Disability Payment System (CDPS) process
 2. Consider the inclusion of pharmacy data and expanded demographic data into CDPS
 3. Develop risk pooling or reinsurance mechanisms to assist CCOs in meeting financial solvency requirements
 - iii. Blended-funding for individuals who are dually eligible for Medicare and Medicaid
 1. CMS has offered states the previously unavailable opportunity to pursue three-way contracts among CCOs, the state, and CMS for blended payment to CCOs set at a level to target savings that can be shared.
 - a. Oregon is preparing for the
 - i. Submission of a formal proposal , which will be the proposal being developed under the dual eligible demonstration contract
 - ii. Negotiation of terms and program structure, in particular to ensure that the proposal meets CMS standards and conditions
 - iii. Signing of a Memorandum of Understanding (MOU) between the state and CMS
 - iv. Development of joint procurement documents and initiation of a joint procurement process
 - v. Signing of three-way contracts among CMS, the state, and CCOs

iv. Incentive Payments

1. CCO global budgets will require reporting on quality indicators including both process and outcomes (see Quality Metrics below). Initially, reporting may constitute adequate performance on all measures. After initial period, minimum performance expectations may apply to core measures but not menu or developmental measures. Exceptional performance on core or developmental measures may qualify CCOs for incentives.

b. **Quality Metrics (Under development and awaiting feedback from the CCO Metrics Work Group and the Oregon Health Policy Board)**

i. Goals/purpose for accountability metrics

Accountability for each arm of the Triple Aim—better health, improved quality of care and patient experience, and reduced per capita costs—is a central tenet of the design of CCOs. CCOs will be held accountable for their performance via Triple Aim-oriented outcomes, quality, and efficiency measures specified by OHA with input from external stakeholders. In combination with financial, contractual, and other incentives, as well as public reporting, challenging but attainable CCO accountability metrics will function both as an assurance that CCOs are providing access to quality care for all their members and an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

ii. Implementation / staging plan for CCO performance measurement

1. Explanation of how metrics will be linked to contracting, budget, and/or incentives
 - a. Incentive design (under development).
 - b. Explanation of minimum performance expectations and targets, as applicable
 - c. Scoring and weighting of metrics for operational purposes
 - i. In calculating an overall quality score for use in the incentive model, measures will be weighted such that physical, mental health and addictions, oral and other types of care count appropriately, even if there are more measures in one area than another.
 - ii. Outcomes and transformation measures will be weighted more heavily than process measures.

2. Initial set of CCO accountability metrics

c. Financial reporting requirements **(Under Development)**

i. Financial reporting process:

1. OHA is developing, in collaboration with DCBS, a process that will allow a CCO to file financial reports with only one regulatory agency

ii. Financial Solvency

1. OHA is working with DCBS, external stakeholders, and the OHPB to identify appropriate financial solvency criteria and processes for CCOs, including those specified in HB 3650:
 - a. Quarterly and annual audited statements of financial position including reserves and retrospective cash flows; and quarterly and annual statements of projected cash flows
 - b. Plain language narrative explanation of the required statements of financial position and statements of projected cash flow
 - c. Development of a statement to be filed by the CCO identifying the entity that will be the guarantor of the CCO's ultimate financial risk and any other entities or persons sharing in that risk
 - d. Disclosure of the CCO's real property holdings and 20 largest investment holdings; and disclosure of the CCO's three highest executive salary and benefit packages
 - e. Disclosure, by category, of the administrative expenses relating to the CCO's provision of services under its CCO contract, and of administrative expenses relating to the CCO's (or its holding company's or affiliated entity's) contracts for other populations, including PEBB, OEBC, and other commercial insurance
 - f. Process (including actuarial analysis) for evaluating the CCO's financial soundness and stability and its ability to bear financial risk, including consideration of
 - i. Risk reserves
 - ii. Reinsurance (type, amount, and threshold level)
 - iii. Risk sharing arrangements with contracting providers and facilities

- iv. Actual and projected enrollment levels, by rate category
- v. The CCO's operating budget, reflecting projected utilization levels and projected expenditures
- g. Sanctions that may be applied when CCOs are deemed financially unsound, and
- h. CCO licensure; there is a remaining question as to whether a new category of licensure should be created for CCOs in order to
 - i. Recognize the unique role of the CCO
 - ii. Avoid duplicative requirements
 - iii. Integrate relevant and useful financial reporting requirements currently part of DMAP oversight of OHP contracting health plans, and currently part of DCBS oversight of commercial insurers and Medicare Advantage plans

8. Implementation Plan: Transition to CCOs (Under Development)

9. Appendices

- a. CCO criteria detail
 - i. Call for applications and certification/contracting process to become certified as CCOs
 Prospective CCOs will complete a certification process that employs the strongest elements of existing practices, including those drawn from the current managed care organization application process and the Medicare Advantage application process (while minimizing duplication of information being requested), with an added focus on health systems transformation by CCOs within their proposed service area. Combined, these elements will address core criteria, integration and innovation criteria, CCO governance, financial projections and budget that align and support achieving the CCO criteria, transformation and health equity strategies. Certification establishes the foundation for contracts that will implement the CCO certification criteria, integration and innovation objectives, metrics and accountability, financial and global budget expectations.
 - 1. Elements from current managed care organization application process include:

- a. Patient rights and responsibilities
 - b. Information management and reporting
 - c. Membership management
 - d. Provider network
 - e. Quality improvement
 - f. Financial reporting and risk management
2. Elements from current managed Medicare Advantage application process
 - a. Core business information
 - b. Facilitate efficiency without duplication of information provided to CMS for Medicare
 - c. Use a process of "attesting" (CCO says it meets the standard) and providing supporting documentation
 3. Integration and Innovation Criteria: Description of the CCO approaches to health systems transformation, including innovations in coordination of care, service delivery, alternative payment methodologies, etc. The specific criteria would be established in advance with latitude for each CCO to tailor its approach to the demographics and health needs of the diverse communities in its service area. Criteria components will be assessed (consider an interview process) and should include:
 - a. Governance Board and Community Advisory Council inform the design of the delivery system, including service types and location where services are delivered, informed by results from the community needs assessment.
 - b. Integrated and coordinated benefits including physical, oral, and addictions and mental health services and supports to populations including Medicaid, CHIP, and Medicare/Medicaid eligible members.
 - c. Realign incentives and refine alternative payment methodologies that change the mix and types of services and sites of care to a level of utilization and investment in services and support that enhance the member experience and improve health outcomes at reasonable costs.
 - d. Assure sufficient capacity and access to care, in all necessary provider types and settings, and is responsive to shifts in care needs and projected member enrollment.

- e. Meaningful member/family/caregiver engagement in all aspects of the health care system, including health promotion/prevention, elimination of health disparities, treatment planning and implementation, quality improvement, cost containment, policy development and system oversight.
 - f. Comprehensive delivery system networks with culturally competent Patient-Centered Primary Care Homes at the helm.
 - g. Individualized treatment and care coordination plans are created and available members/families/caregivers and all providers responsible for the care of each member.
 - h. Delivery system network agreements include treatment, care coordination and transition of care standards including timelines and method for information sharing.
 - i. Delivery system design and services are attentive to health disparities and health equity in meaningful, measurable ways, with incentives considered for successful outcomes.
 - j. Coordination and support for health information technology to enhance care coordination, provider communication, quality improvement and cost containment.
 - k. Providers are supported with technical assistance, information, health information technology and care coordination supports.
 - l. Written agreement with each Local Mental Health Authority in which the CCO operates to coordinate the management of a community-based mental health and addictions system.
- 4. Consider tiered approach to achieving full CCO capability beyond the “must-be-met” core criteria
 - ii. HIT and HIE criteria detail (Under Development, draft outline available)
 - b. Alternative dispute resolution (Under Development)
 - i. Provide a predictable and fair process for CCOs and health care entities related to refusal to contract
 - ii. Process will include the use of an independent third party arbitrator
 - c. Overview of CMS design proposal for integration and coordination of health care delivery systems for individuals who are dually eligible for Medicare and Medicaid.

Note regarding HB 3650 Section 16 Health care cost containment:

Separate from this business plan, OHA will provide the legislature a study and recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures, while protecting access to health care services for those in need and protecting their access to seek redress through the judicial system for harms caused by medical malpractice.

DRAFT

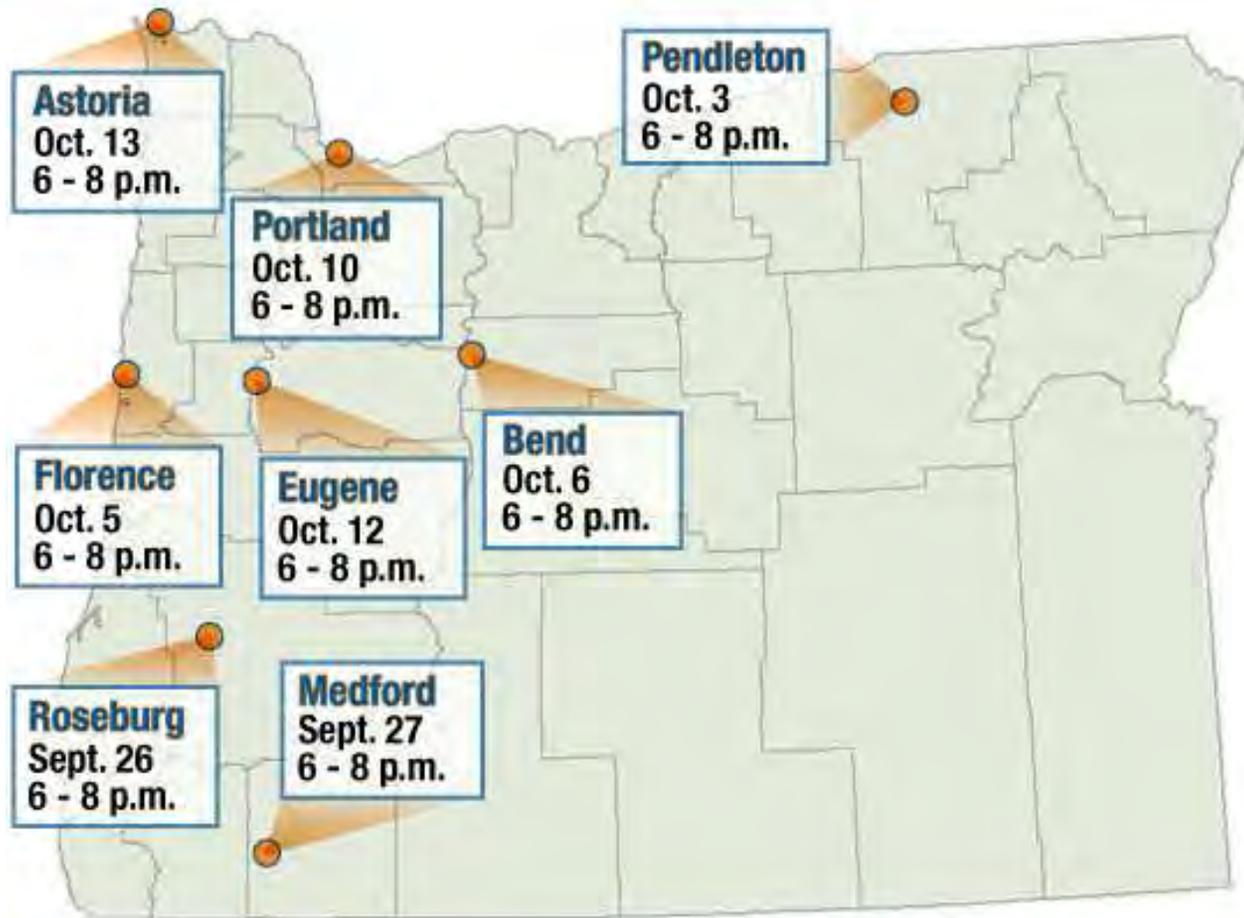
Community Meetings Recap: Transforming the Oregon Health Plan

Oregon Health Policy Board
November 8, 2011

Jeremy Vandehey
Oregon Health Authority



Locations



Attendance

Roseburg (9/26/2011) -	120
Medford (9/27/2011) -	120
Pendleton (10/3/2011) -	65
Florence (10/5/2011) -	65
Bend (10/6/2011) -	95
Portland (10/10/2011) -	320
Eugene (10/12/2011) -	165
<u>Astoria (10/13/2011) -</u>	<u>55</u>
Community Meetings:	1,005
<u>Online survey</u>	<u>284</u>
Total:	1,289

Attendees

- Clients
- Health care industry
 - Providers – physicians, nurses, naturopaths, chiropractors, mental health, dentists
 - Home care workers
 - Health plans
 - Hospitals
- Elected officials
 - Legislators
 - County commissioners

Mass media coverage

- 34 interviews and stories
 - Print, radio, television
 - Message: Better health, lower cost, building on local innovations



Agenda

- Welcome/logistics
- Video welcome from Governor Kitzhaber
- Power Point presentation “Transforming the Oregon Health Plan”
- Example of local innovation
- Brief question and answer period
- Small, round table discussions
- Report back
- Longer question and answer/comment period

Small group discussions/online survey

1. Think about the best health care experience you have had. What were the key features that made it the best?
2. What is the responsibility of the patient to be an active participant in their care plans?
3. Coordinated Care Organizations need to be accountable to and engage the community they serve.
 - a. How should a CCO be accountable to its community?
 - b. How would the Oregon Health Authority (and local communities) know that CCOs are engaging the communities they serve in a meaningful way?

Major Themes

- Comprehensive health care that meets the needs of the whole person is essential.
- Mental health services should be better integrated into the health care system.
- Economic health and community health are linked.
- Provide assistance and support to communities as they develop CCOs.
- Provide clear direction and metrics to evaluate CCO success.
- Preserve local character and build on existing strengths.

Major Themes (pg 2)

- Provide sufficient guidance while maintaining flexibility.
- Local communities should be meaningfully engaged in the CCO development and governance.
- Clients and beneficiaries perspectives and experiences should be included.
- Determination of funding should be transparent and take local conditions into consideration.
- CCO development should be a first step towards broader reform.
- Community education is key.

Major Themes (pg 3)

- OHA should be a partner in communities.
- Preventive care is essential.
- Quality of care should not depend on where you live.
- Build on what works.
- Support coordination and reduce bureaucracy.
- Liability should be balanced.

Overall impressions

- Right questions at right time – communities are talking and becoming engaged
- Oregonians are eager for a new way to get health care that focuses on patients, not protecting the current system.
- Oregonians are ready for a change to get costs under control.
- There will be challenges.
- Many communities have already started working on how they will change the way they do business
- Two key ingredients:
 1. local community flexibility (no two areas exactly alike)
 2. quickly remove bureaucratic barriers

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Health Information Technology Oversight Council

OHA Director's Report, November 4th, 2011

Below is a summary of HITOC and related workgroups, panels and stakeholder meetings from October 1st through November 4th, 2011. Full meeting summaries are available through the Office of Health Information Technology (OHIT).

October 5th, Legal and Policy Workgroup: Staff updated the workgroup on HITOC's recent decision to delay the rules on the consent policy. Staff presented information about the recent proposed changes to HIPAA and Clinical Laboratory Improvement Amendments (CLIA), and provided a status update on the HIE participation agreement. The Legal & Policy workgroup agreed with HITOC's decision on the consent policy and discussed how to improve the process of implementing the opt-out consent policy in the future. The workgroup proposed convening a subcommittee to review the draft rules and improve the current language in light of the feedback received during the public comment period. Also, the subcommittee was asked to analyze what questions will need to be answered before HITOC moves forward with implementing the opt-out consent policy. Finally, the workgroup agreed that a challenge in writing the consent policy into rule stems from the fact that Oregon's existing HIE capabilities are not fully understood. It is anticipated that the subcommittee will identify areas needing further clarification prior to implementation of the consent policy.

October 6th, HITOC: Sean Kolmer was invited and provided an update on Oregon's Health System Transformation (HST) initiative including all four Workgroups. A reoccurring topic among the Workgroups has been health information technology (HIT) and health information exchange (HIE), and how these tools might best possibly support Coordinated Care Organizations (CCO). HITOC members emphasized the need to educate CCO Work Groups and staff on HIT, HIE and electronic health records (EHRs) technology. Staff provided members with updates on the Oregon e-Health Pledge, the administration simplification initiative, Oregon's RFP for HIE services, and the successful launch of Oregon's Medicaid EHR Incentive Program. Members reviewed and voted on quality as a fourth HIE priority area for Oregon as it aligns with CCOs and health transformation. In March 2012, an all-day retreat will be held for HITOC in lieu of their monthly meeting.

October 26th, HITOC Webinar: At the October 11th, 2011 Oregon Health Policy Board meeting, HITOC was asked for advice and input on possible HIT/HIE needs for future CCOs. Consequently, it was determined a webinar meeting prior to HITOC's monthly November meeting would be helpful in terms of providing background information on Oregon's CCO work. The purpose of the webinar was to provide HITOC members an opportunity to review proposed CCO HIT domains of responsibility drafted by OHIT staff. Members provided feedback and identified the next steps for developing proposed CCO HIT domains of responsibility to be considered at HITOC's November 3, 2011.

October 27th, Consumer Advisory Panel: The Panel was updated on HITOC's recent decision to delay the rules on the consent policy for health information exchange (HIE). Staff outlined considerations taken

into account regarding this decision as well as presented information about a newly created subcommittee. The subcommittee will explore next steps needed to successfully implement the opt-out consent policy as Oregon's HIE services develop and expand in the future. The subcommittee includes representation from the Legal & Policy workgroup, the Consumer Advisory Panel and other health care stakeholders. The workgroup also reviewed the proposed changes to HIPAA and CLIA and received an overview of Oregon's Coordinated Care Organizations (CCOs).

CCO Criteria Question 1: Financial Solvency

Putting yourself in OHA's shoes, how would you evaluate a CCO's governance, given the HB 3650 requirement that:

Each CCO has a governance structure that includes:

- A) A majority interest consisting of the persons that share in the financial risk of the organization;
- B) The major components of the health care delivery system; and
- C) The community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community.

<u>Name, City</u>	<u>Comment</u>
Sydney Thompson, Lincoln City, OR	Whether or not existing providers in rural communities are being included in the development of CCOs. Our medical practice is THE ONLY independent medical group between Newport and Tillamook here on the coast. If Hospital systems decide not to coordinate care with our group and instead create their own provider groups within the area who does that benefit exactly? I am greatly concerned Bayshore Family Medicine will NOT have a seat at the table when CCO development begins.
jeri olson, portland oregon	NOT GIVING SO MUCH AUTHORITY TO CERTAIN EMPLOYEES WITHIN THE OREGON HEALTH AUTHORITY TO AVOID THE BULLYING THAT IS CURRANTLY TAKING PLACE.
Anonymous	There is no need to ensure the financial solvency of CCOs. As these are businesses solely interested in profit, "ensuring financial solvency" is code word for ensuring that the gravy train keeps on running no matter how much profit the rich rascals (previously described in this survey as "persons that share in the financial risk of the organization") suck out of the system. There is no need to mortgage the health and lives of Oregon citizens to ensure the fiscal solvency of for-profit organizations ran by rich people who care not one wit for the lives of the masses. How can we be going down this road? Has history (particularly the last 4 decades) taught us nothing? Is there no one able to think? How can we think we are fixing the current problems when the legislation intended to do so prioritizes profit over everything and only allows the citizens a minority voice, i.e., the opportunity to cry while they die.

CCO Criteria Question 2: Governance

HB 3650 calls for the development of a proposal for financial reporting requirements for CCOs to ensure against the organization's risk of insolvency, with filing of financial reports to only one regulatory agency.

<u>Name, City</u>	<u>Comment</u>
Bria Wickizer, Salem, Oregon	The CCO's job is to ignore any person not economically viable. Health care delivery will be what it always was the un-insured get booted, and the insured are milked for what their policies are worth. There isn't really any decision-making at all.
jeri olson, portland oregon	The community at large to ensure the organization's decision-making is not soaking up government funds
Anonymous	Given that a majority interest must consist "of the persons that share the financial risk of the organization," it doesn't really matter how you "evaluate their governance." This constraint has placed the primary or sole purpose of the organization as "making profit." Failure to meet goals such as improved health outcomes or reduced cost is guaranteed. The legislation must be amended to indicate that lives are more important than profit, that is that a majority interest must consist of persons whose health and lives depend on CCO, that is "persons that share in the biological risk of the organization." The current wording assures that power within the CCO is held solely in the hands of those who seek to profit from it. The language was probably crafted by a lobbyist, or perhaps a legislator who is beholden to the rich rascals that control their industry.

Medicare-Medicaid Question 1: Care Coordination

House Bill 3650 states that each member of a Coordinated Care Organization receives integrated person-centered care and services to provide choice, independence and dignity. Care coordination must occur across a wide range of service settings and for a diverse set of social, physical and mental health conditions.

1. What would effective care coordination look like from the perspective of a beneficiary, a care giver or family member and a provider?
2. What key elements in a CCO proposal would demonstrate that it can effectively coordinate care? Consider individuals with complex care needs such as those accompanying serious mental illnesses, chronic medical conditions, severe dementia, traumatic brain injury and limitations in 3 or more activities of daily living etc.

<u>Name, City</u>	<u>Comment</u>
Sydney Thompson, Lincoln City, OR	<p>1. Effective care coordination would incorporate existing patient/provider/community resources as opposed to duplicating services for the sake of creating a CCO.</p> <p>For example, Adventist Health in Tillamook just decided this past week to install a satellite clinic in Pacific City, which would dramatically alter the provider landscape in our rural community, and have a potentially devastating result on our practice.</p> <p>As independent practitioners, we cannot rely on the financial backing of large systems . If Adventist Health puts a location in Pacific City there is a high likelihood our practice would be significantly negatively impacted.</p> <p>You cannot duplicate services within communities and think access to care is somehow immediately improved, or quality will benefit. Our practice is in the process of attesting for the PCPCH model and if system hospitals are going to ignore us in developing CCOs the purpose is already defeated.</p>
jeri olson, portland oregon	1) family member
Anonymous	1. For a Provider, it will look like a chance to perform more "work," bill the state in more ways, make more profit per customer while serving more customers, increasing profits at an even faster rate than the current, unsustainable rate, ultimately bankrupting the state and the nation to the benefit of a few grossly rich individual while simultaneously endangering the health and lives of most Americans.

Medicare-Medicaid Question 2: Transitions of Care

House bill 3650 establishes that members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long term care setting.

3. What would effective transitional care look like from the perspective of a beneficiary, a care giver or family member and a provider?
4. What key elements in a CCO proposal would demonstrate that it has an effective strategy for transitional care? Consider again individuals with complex care needs such as those accompanying serious mental illnesses, chronic medical conditions, severe dementia, traumatic brain injury and limitations in 3 or more activities of daily living etc.

<u>Name, City</u>	<u>Comment</u>
jeri olson, portland oregon	<p>return to family member.</p> <p>Did you ever ever think of asking the patient what would work best for them????????</p>

Outcomes, Quality and Efficiency

The primary discussion questions are the same for each topic area:

Are any of the potential measures listed "must-haves"?

Should any be dropped from consideration?

Are there other measures not listed that should be candidates?

<u>Name, City</u>	<u>Comment</u>
jeri olson,portland oregon	TAKE AWAY THE GOVERNMENT CONTROL AND LET PEOPLE LIVE THEIR LIVES. DO NOT INTERFERE UNLESS THE HELP IS REQUESTED. BE OF SERVICE TO THE MENTALLY ILL, STAY FOCUSED ON WHAT WORKS FOR THE PATIENT, NOT WHAT WORKS FOR THE EMPLOYEES.