

2014 Coordinated Care Model Alignment Workgroup

June 18, 2015

11:00 a.m. – 1:00 p.m.

General Services Building (Neahkanie Room)

1225 Ferry Street SE

Salem, OR 97301

Public listen-only conference line: 888-363-4734; Participant code: 1050791

Meeting #6			
#	Time	Item	Lead
1	11:00	Updates <ul style="list-style-type: none">• OEBC RFP• CORE Tracking Transformation report	Veronica Guerra, OHA
2	11:15	SHEW incorporation into CCMA workgroup	Leslie Clement, OHA Stacy Delong, OHA
3	11:35	Review scope of work template outline	Beth Waldman, Bailit Health Purchasing
4	12:00	Environmental scan feedback and round robin <ul style="list-style-type: none">• Round robin question: what are members seeing on the ground and what is the impact on our work?	Jeanene Smith, OHA
5	12:25	Population Health Alliance presentation	Veronica Guerra Aaron Crane, Population Health Alliance
6	12:50	Public Comment	
7	1:00	Adjourn Meeting	

Meeting materials:

- CORE Tracking Transformation report
- SHEW charter, member roster, December 2014 report to OHPB, summary of OHPB decision
- Scope of work template outline
- Environmental scan report

TRACKING TRANSFORMATION

ASSESSING THE SPREAD OF COORDINATED CARE IN OREGON

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EXECUTIVE SUMMARY

PROJECT OVERVIEW

Coordinated Care Organizations (CCOs) are accountable for the Triple Aim of reducing costs, improving patient experience, and improving health at the population level. CCOs are encouraged to follow best practices to meet those aims, but there is no “set” view of what transformation looks like on the ground within any given CCO. Assessing what CCOs are actually doing is critical to understanding which elements of transformation are key drivers of population outcomes.

The Center for Outcomes Research and Education (CORE) in partnership with OHA and researchers at OHSU’s Center for Health Systems Effectiveness (CHSE) was charged with assessing the “spread” of key elements of Oregon’s CCO model across the health care market. We identified 11 *transformation domains*, loosely organized into four broad categories: governance and collaboration, data & information, care delivery transformation, and payment & finance— that represent elements of transformation integral to Oregon’s coordinated care model. Our team of research and policy stakeholders collaboratively designed a tool that could measure an organizations’ place along a continuum of possible transformation within each domain. We also designed qualitative interview guides to further explore the domains and go beyond the survey numbers.

WHAT WE DID

SURVEYS: We used a structured survey tool — one aimed at payer organizations, the other at provider organizations — to collect data on the 11 transformational domains. Our sample consisted of 151 organizations that were organized by payer organizations (CCOs and Health Plans) and provider organizations (Hospitals, FQHCs, Physician Groups, and Mental Health Organizations). We received a total of 103 responses, a 68% response rate.

QUALITATIVE INTERVIEWS: Using survey results, we identified a series of supplemental qualitative questions that were used to contextualize and add a deeper understanding of what transformational activities organizations were or were not doing. We determined the sample by analyzing the survey responses and identifying “outliers” - organizations that appeared to be on the high and low end of transformational activities. We conducted 17 interviews with respondents across all the organization types.

WHAT WE FOUND

STARTING NEAR THE TOP

CCO PRIORITIES: COMMUNITY ENGAGEMENT & INTEGRATION

WHAT THE SURVEY TELLS US: At baseline, the domains with the survey scores that represent organizations being the furthest along the transformational spectrum were *community engagement* and *integrated care*—domains closely associated with the CCO model.

ADDITIONAL CONTEXT: Interviews suggest that soliciting community feedback is common for all organizations, but there is room to grow in terms of providing them with an authentic voice in governance. Interviews also underscored that integration efforts are prioritized and underway, but breaking down the silos of physical, behavioral and dental health present a significant challenge.

OPPORTUNITY TO IMPROVE

UPSTREAM POPULATION HEALTH

WHAT THE SURVEY TELLS US: Lower survey scores for all the organizations were related to shifting toward *upstream population health* management. Integrating and leveraging data for population health management, as well as changing incentives to promote population health, are all areas in which there is room to grow.

ADDITIONAL CONTEXT: Interviews indicate that data systems are a high priority for all organizations. Health plans with the national presence have sophisticated systems, but others are working to have similar capabilities. Incentivizing population health is also paramount; organizations are working to move toward risk-based contracts, with a handful already employing more transformative financial reimbursement models.

NEXT STEPS

This longitudinal study is designed to follow transformation efforts along all of the domains with another round of surveys and interviews, with the addition of a purchaser survey, in mid – 2016. A final report will be delivered in September, 2016.

TRACKING TRANSFORMATION

ASSESSING THE SPREAD OF COORDINATED CARE IN OREGON

INTRODUCTION

This document outlines results from an assessment of Oregon's transformation landscape conducted by the Center for Outcomes Research & Education (CORE). The study's intent is to assess the "spread" of key elements of Oregon's coordinated care model across the health care market. Using a tool developed in partnership with key stakeholders, we assess Oregon's status across 11 key domains of health care transformation, both in total and for distinct types of health care organizations. We supplement the survey data with a series of open-ended interviews designed to contextualize findings and provide a deeper view of transformation efforts across the state. Goals of the study include:

Goal 1. Track transformation using an organizational survey tool developed around key elements of delivery system transformation.

Goal 2. Supplement the survey with qualitative interviews designed to assess the shape and nature of transformation efforts.

Goal 3. Use results from both efforts to improve and refine the tool in order to reassess transformation in 2016.

BASELINE DATA

These data are intended to act as a **baseline**: they represent Oregon's status on key transformation domains as of early 2015. We will re-assess these same qualitative and quantitative measures again in early 2016 in order to track change in key transformation domains, both in total and within distinct types of health care organizations.

BACKGROUND

In 2012, just prior to the ACA Medicaid expansion, the state of Oregon embarked on a radical overhaul of its Medicaid system. Leveraging a localized version of the accountable care model, the Oregon Health Authority (OHA) shifted risk for Medicaid costs to regional public-private collaboratives called Coordinated Care Organizations (CCOs). Inspired by the health reform landscape, Oregon's CCOs are ambitious multi-stakeholder umbrella organizations, including health plans, public health departments, and networks of physical health care, behavioral health care, and dental health care providers. CCOs are regionally defined—they cover Medicaid beneficiaries within a defined geographic boundary — and are accountable for controlling costs while also meeting strict quality standards. Their governance models must include a community advisory council made up of 51% Medicaid consumers, ensuring they retain strong links to the population they serve.

WHY ASSESS TRANSFORMATION?

Oregon's model holds CCOs accountable for the Triple Aim of reducing costs, improving patient experience, and improving health at the population level. However, it also explicitly gives local communities the freedom to identify key priorities and implement local solutions and strategies to meet those aims. As a result, while CCOs are encouraged to follow best practices, there is no "set" view of what transformation looks like on the ground within any given CCO. Assessing what CCOs are actually doing is critical to understanding which elements of transformation are key drivers of population outcomes.

At the same time, Oregon's transformation was never intended to be limited to just Medicaid. CCOs were always intended to catalyze a larger transformation of the state's health care system. Over time, elements of the coordinated care model might spread to other market sectors, reshaping care beyond the boundaries of Medicaid. Spread might come directly from the CCOs — a member organization that redesigns processes for its Medicaid members might deploy them in service to all its members, for instance. But CCOs are not the sole engine of innovation: the spread of transformation elements could also be driven by hospitals and health plans aggressively implementing reforms in an attempt to stay ahead of the curve and respond to the state's changing health care landscape. Understanding the true scope of delivery system reform in Oregon requires assessment not just of what CCOs are doing, but what other health care organizations are doing as well.

TRACKING TRANSFORMATION

Oregon is working to transform its health care system from one defined by fragmentation and rising costs to something that is better integrated, cost-controlled, and produces better outcomes for communities. In this report, we begin to measure what that transformation work looks like on the ground by collecting an initial round of data capturing the state's status in eleven key domains of transformation. These data will act as a benchmark against which future assessments can be compared, allowing us to track the nature and shape of health care transformation in Oregon over time.

"There is no finish line to improvement. It's an on-going project. We need to measure against what we did before and keep plugging ahead."

—Interview Participant at a Hospital System

TRANSFORMATION DOMAINS

WHAT WE MEASURED

Working in partnership with OHA and researchers at OHSU’s Center for Health Systems Effectiveness (CHSE), we identified a set of broad *transformation domains* that represent elements of transformation integral to Oregon’s coordinated care model, such as payment reform or integrated care. Our initial list of domains was informed by the results of interviews and document analysis conducted by Oregon researchers from earlier studies of Oregon’s CCOs, as well as conversations with key state officials.

Once we identified the key domains of transformation, we designed a tool that could measure an organization’s place along a continuum of possible transformation within each domain. The tool is designed to “score” organizations in terms of transformation elements, with results ranging from 0 (no major elements of transformation apparent yet) to 10 (indicating that many elements of transformation are present and widely spread throughout the organization). We also used qualitative interviews to further explore and contextualize the scores produced by our survey tool, allowing us to get beyond the numbers in order to understand the specific nature of transformation efforts across the state.

TRANSFORMATION DOMAINS

The eleven domains our tool is designed to capture are summarized below, and fall into four broad areas: governance and collaboration, data & information sharing, care delivery transformation, and payment and finance. Each domain is a function of multiple individual survey items that combine into a summary score representing an organization’s place along the potential transformation continuum. The average of those scores for all organizations in a given sector (eg, all health plans) represents that sector’s overall transformation score.

INTERPRETING DOMAIN SCORES: Domain scores are not *performance scores*. Our tool does not make assumptions about what any organization *should* be doing. Rather, scores are best seen as representing how densely transformational elements are present within a given sector at a given point in time. Thus, for example, a score of 5 in the domain of *integrated care* represents a moderate prevalence of such initiatives across the sector in question, not performance against some standard of practice.

LIST OF TRANSFORMATION DOMAINS

We track 11 distinct transformation domains, loosely organized into four broad categories: governance and collaboration, data & information, care delivery transformation, and payment & finance. Each domain receives a “score” computed from answers to multiple survey questions (described below).

GOVERNANCE & COLLABORATION

CROSS-SECTOR PARTNERSHIPS	<i>Health care works closely with other sectors to improve outcomes.</i>
COMMUNITY INVOLVEMENT IN GOVERNANCE	<i>Authentic engagement with consumers and community members.</i>

DATA & INFORMATION SHARING

INTEGRATED & SHARED HEALTH CARE DATA	<i>Data on whole-person care available and used to shape efforts.</i>
USING DATA FOR POPULATION MANAGEMENT	<i>Data from other organizations/sectors used to promote broad health.</i>

CARE DELIVERY TRANSFORMATION

INTEGRATED CARE MODEL (PHYS, BEH, DENTAL)	<i>Implementation of whole-person care models.</i>
BETTER COORDINATION; RIGHT CARE IN RIGHT PLACE	<i>Efforts to optimize care delivery for efficiency and effectiveness.</i>
PREVENTION & UPSTREAM INTERVENTION EFFORTS	<i>Strategies to address key determinants of health thru primary prevention.</i>
WORKFORCE TRANSFORMATION & DIVERSIFICATION	<i>Use of non-traditional and diverse workforces to change care.</i>

PAYMENT & FINANCE

OWNERSHIP OF RISK (PROXIMITY TO POINT OF CARE)	<i>Risk moves closer to providers at the point of patient engagement.</i>
INTEGRATED RISK	<i>Risk is for all types of health, not separated into silos.</i>
ALIGNING INCENTIVES & VALUE	<i>Incentives for providers to focus on smart care that improves health.</i>

METHODOLOGY

OVERVIEW OF APPROACH

ORGANIZATIONAL SURVEY: We used a structured survey tool to collect data on transformation activities from key leaders at various health care organizations around Oregon. Data were used to compute scores within each of our 11 transformation domains for each participating organization. Both versions of the tool (one for payers, one for provider organizations) are included in the Appendix.

IN-DEPTH INTERVIEWS: We conducted a series of open-ended, in-depth interviews with a subset of respondents to the organizational survey in order to explore transformational work across the state in greater depth.

SAMPLE

SURVEY: We compiled a list of 288 major health care organizations in Oregon, including both payers and providers, then drew a random sample of 151 such organizations for data collection. We organized participants into sectors, including payer organizations (CCOs and Health Plans) and provider organizations (hospitals, FQHCs, Physician Groups, and Mental Health Organizations).

PAYERS	TOTAL	SAMPLE	COMPLETED
CCOs	16	16	12
Health Plans	16	16	10
PROVIDERS	TOTAL	SAMPLE	COMPLETED
Hospitals	61	40	31
FQHCs and CHCs	32	32	20
Physician Group/IPA	7	7	5
Mental Health Orgs	148	40	25
All Organizations	288	151	103

(regardless of CCO membership); for example, hospitals that were part of CCOS or larger health systems were asked to speak from the vantage point of their individual entity.

QUALITATIVE: We used initial survey responses to look for “outliers” - organizations that appeared to be doing particularly transformative work along any given domain — to interview. We attempted to spread respondents across organization types to ensure representative perspective. We completed 17 interviews: 5 payers and 12 providers.

RESPONSE RATES: We sampled 151 organizations and received 103 responses, a 68% response rate. Note: See appendix for more details on the interview and measurement plan.

WHAT THIS TELLS US ABOUT TRANSFORMATION

Our primary intent in this project is to assess the *spread* of key transformation elements from CCOs to other health care sectors. By measuring CCOs, we can capture progress in key domains occurring as a direct result of the CCO legislation. By measuring the same domains in other health care organizations, we can compare the presence of transformational elements between CCO and non-CCO sectors. And by tracking scores over time, we can look for spread by identifying cases where other health care organizations begin to implement ideas initiated within CCOs in order to produce comparable domain scores.

SURVEYS

We deployed a pair of online surveys — one aimed at payer organizations, the other at provider organizations — which were delivered to key industry executives, including CEOs, CFOs, and similar officials at key health care organizations around the state.

The surveys were designed to capture baseline high-level data on organizations along a series of dimensions mapped to the transformation domains, producing a score from 0-10 for each domain. Answers to a specific questions contribute “points” to domain scores, and the number of points created within a domain tell us about the total presence of transformational elements within that domain. For instance, a score of 0 in the domain of *integrated care* would represent a complete absence of such initiatives, while a score of 10 would indicate a very strong presence of integrated care initiatives within the responding organization.

INTERVIEWS

For each of our transformation domains, we also identified a series of supplemental qualitative questions that could be added to contextualize and explore the survey results (included as Appendix B). These questions were explicitly designed to add deeper understanding to the domains; qualitative results did not contribute to the scoring.

We analyzed interviews to help characterize the exact nature of each organization’s work in a given domain and identify new areas of transformation relevant to the tool. Results will be used to refine the tool for future iterations.

DOMAIN SCORING

Scores for each domain are based on responses to anywhere from 3 to 9 specific survey questions. Every survey item represents one type of potential transformation activity an organization could be doing, and has three possible responses, ranging from not much at all (on the right of the scale) to widespread presence or advanced implementation (on the left of the scale).

Organizations receive points within a domain based on how they answer questions: 0 points for an answer that indicates no activity of that type, 1 point for limited activity or progress, and 2 points for widespread or more developed efforts. Scores for domains are a function of how many points an organization accumulates across all items that contribute to that domain.

STANDARDIZATION: Domains have a varying number of questions that contribute to their total scoring. For ease of interpretation, all scores were mathematically standardized to a scale of 0-10, with 0 representing no meaningful presence of transformation within that domain and 10 representing widespread transformation.

USING DOMAIN SCORES: Domain scores can be compared to one another (allowing for a quick comparison of different types of transformation across organizations, for example), or tracked over time (allowing for the spread of transformation to be tracked over time). Organizational scores can grow either by adding new transformation pilots or efforts (moving points from 0 to 1 within a given question), or by furthering the spread of existing pilots or efforts (moving from 1 to 2 within a given question).

DOMAIN MAPPING

The contribution of survey items to each transformation domain is summarized below. Item numbers refer to the surveys, which are available for review in the Appendix.

	PAYER SURVEY QUESTIONS	PROVIDER SURVEY QUESTIONS
GOVERNANCE & COLLABORATION		
CROSS-SECTOR PARTNERSHIPS	8ADE (3 items)	6DE, 11ADE (5 items)
COMMUNITY INVOLVEMENT IN GOVERNANCE	8BC, 9ABC, 10 (6 items)	11BC, 12ABC, 13 (6 items)
DATA & INFORMATION SHARING		
INTEGRATED & SHARED HEALTH CARE DATA	6AEFHI (5 items)	7, 8AEFHJ (7 items)
USING DATA FOR POPULATION MANAGEMENT	6BCDG (4 items)	8BCDG (4 items)
CARE DELIVERY TRANSFORMATION		
INTEGRATED CARE MODEL (PHYS, BEH, DENTAL)	2ABCD, 7B (5 items)	6ABC, 9AD, 10B (6 items)
BETTER COORDINATION; RIGHT CARE IN RIGHT PLACE	4A, 7ACG (4 items)	9E, 10AEGI (5 items)
PREVENTION & SDH-INFORMED CARE	4BD, 7DEF (5 items)	10CDFH (4 items)
WORKFORCE TRANSFORMATION & DIVERSIFICATION	4AC, 5 (3 items)	9BC (2 items)
PAYMENT & FINANCE		
OWNERSHIP OF RISK (PROXIMITY TO POINT OF CARE)	3ABCD (4 items)	1DEFG, 2 (5 items)
INTEGRATED RISK	1ABCD (4 items)	1ABC (3 items)
ALIGNING INCENTIVES & VALUE	4DE (2 items)	3ABCD, 4ABCD, 5 (9 items)

SCORING EXAMPLE (FROM PROVIDER SURVEY)

4. How easy is it for care providers in your organization to get or share the following kinds of information on your patients?

	Easy or routine	Possible, but not routine	A significant challenge
A. Share data with other providers in your organization to coordinate care	0	0	0
SCORE	2	1	0

In this example, a provider organization that answers “possible, but not routine” would gain 1 point toward its transformation score in any domain associated with item 4A. In our proposed crosswalk, item 4A on the provider survey is associated with the “integrated and shared health care data” domain, so the organization would receive 1 point toward that domain score.

RESULTS OVERVIEW:

TRANSFORMATION TO DATE

THE STATE OF TRANSFORMATION

We assessed the prevalence of transformational elements within each domain on a scale from 0 (not transformed at all, representing traditional health care systems) to 10 (the highest possible score, representing organizations that have implemented a wide range of initiatives very broadly across their membership). Results from our 2015 baseline survey suggest that Oregon has already seen widespread transformation, with many elements of the coordinated care model permeating CCOs and other health care entities.

MOST TRANSFORMATION: Overall, Oregon has made the most progress in areas related to *community engagement* and *integrated care* — two domains explicitly tied to the CCO model. CCOs have led the way in community engagement, but not necessarily in integrated care—health plans and providers have also been working hard to create integrated care, and their efforts are apparent in their scores.

LEAST TRANSFORMATION: The lowest transformation scores congregate in areas representing *upstream population health*, especially in the use of data for population health management.

Finance reform centered on changing risk models is also still in its infancy in Oregon, though some individual organizations have made extensive progress.

Scores (0-10, 10=most transformed)

TRANSFORMATION DOMAINS	Statewide N=103	CCOs N=12	Health Plans N=10	Providers N=81
Community Involvement in Governance	5.8	7.2	6.2	6.0
Cross-Sector Partnerships	6.1	7.9	6.5	6.5
Integrated & Shared Health Care Data	5.8	6.2	6.4	6.2
Data for Population Health Management	4.5	4.0	3.9	3.8
Integrated Care Models	7.2	7.4	8.0	6.9
Better Care Coordination	7.2	7.2	7.5	6.9
Prevention & SDH-Informed Care	6.3	5.2	5.2	7.2
Workforce Transformation	6.3	4.0	3.7	7.2
Ownership of Risk	4.2	5.0	4.5	4.4
Integrated Risk	4.6	4.6	8.5	4.1
Aligning Incentives & Value	4.4	4.6	5.3	4.2

TOP THREE REFORMS: PAYERS	TOP THREE REFORMS: PROVIDERS
Integrated Care Models	Prevention & SDH Informed Care
Better Care Coordination	Workforce Transformation
Cross-Sector Partnerships	Integrated Care & Care Coordination
SLOWEST PROGRESS: PAYERS	SLOWEST PROGRESS: PROVIDERS
Data for Population Health Management	Data for Population Health Management
Workforce Transformation	Integrated Risk

WHO IS LEADING THE WAY?

Both payers and providers have made good progress around care coordination and integrated care, and both have indicated that there have been challenges in supporting population health strategies with the appropriate data. Changing where risk lies in the system has also been a challenge for provider groups and CCOs, but Health Plans have demonstrated good progress in this area, mostly through progress in non-Medicaid markets.

Overall, data suggest that the greatest challenges lie in areas that require the greatest shift in both thinking and operations— coordinating care better is one thing, but shifting from “providing care” to “population health” may require new ways of thinking, new workflows, and new types of data relationships that health care organizations are not always ready to implement quickly. Over time, we will track the changes in these scores in order to measure Oregon’s progress along each of these transformation domains.

MORE DETAILED RESULTS

For more information about how Oregon organizations are transforming within each domain, including a more detailed breakout of performance for CCOs, HEALTH PLANS, hospitals, FQHCs, IPAs/physician groups, and mental health organizations, please see pages 6-28 of this report.

WHY ARE ORGANIZATIONS RESPONDING TO THE CALL OF REFORM?

Oregon's CCOs have made important strides in many transformation domains, but they are not alone: other health plans equal or even exceed CCO performance in some cases, as do some provider organizations. Results from our organizational survey clearly suggest that health care transformation is not limited to Oregon's CCOs.

Oregon's CCO reform did more than just implement new legislation—it also changed the conversation about the future of health care in the state. As part of this study, we completed in-depth, open-ended interviews with health care CEOs and other executives designed to explore the key drivers of transformation. Throughout those interviews, we heard a consistent desire, especially among Oregon-based organizations, to undertake transformation because it was the “right thing to do.” Respondents believed transformation would keep them competitive, but also expressed a genuine desire to develop a health care system that works better for their communities.

A BELIEF THAT TRANSFORMATION WILL RESULT FROM MARKET FORCES

“The wind is blowing in that [transformational] direction, but when you see what’s happening in the market, a lot of folks are betting on the retail play. All of these consulting firms are developing their own exchanges with the focus on the point of enrollment which is what the Affordable Care Act focused on. ACOs are focusing a lot on the point of care, but if you talk to delivery systems outside of Oregon, you see those ACOs focusing on building out their network first and then focusing the point of care — they are saying ‘now that we’ve got five-thousand positions in the hospitals in our network, let’s figure out how we are consistently defining quality, what are the common measures, and how we get our disparate systems to speak to each other. That could be a three to five year endeavor before you start focusing on ‘what are we actually doing today to reduce the cost of care?’ So I think the interventions that focus on doing different treatments and focusing on preventative measures will postpone the substantial performance improvement that we all are hoping to achieve.”

A DESIRE TO STAY AHEAD OF TRANSFORMATION

“We do not want the state to dictate the outcomes and metrics that are important to our community. The state prefers to look broader than just Medicaid and to have a stronger voice. We know if the population health model is being used at the state level, it will eventually show up in the commercial market as well. It will show up in how we deal with public employee benefits and the community doesn’t want it to be handed down to them from the state. We want to build and fund our local priorities and have a system in place to do that successfully. It’s very hard to stay ahead of the state on anything CCO driven and keep up with the changes, so if you don’t take the long term approach to look at what you want...you’re constantly going to be reacting.”

NEXT STEPS FOR THIS DATA

REFINING THE TOOL: The design team will continue meet to refine our assessment tool before the next round of fielding: we are actively working to create a version of the tool aimed at *purchasers*, and are also looking at adding new questions around risk that will help elucidate ways payers and providers are working to put more risk on patients by giving them more “skin in the game.” The next iteration of assessment will include these (and potentially other) changes.

LONGITUDINAL DATA: The data collected here represent an initial descriptive snapshot — a baseline measure, taken in early 2015 — of the state of health care transformation in Oregon. Next, we will repeat our assessment, using the resulting data to track changes in scores within each domain over time and examining those changes in total for the state and separately within each sector.

ALL PAYER, ALL CLAIMS ANALYSIS: We have also provided these data to colleagues at OHSU’s Center for Health Systems Effectiveness (CHSE), who are undertaking a companion study employing claims data to examine the spread of transformation across Oregon’s health care markets over time.

LIMITATIONS

Although these data represent an important snapshot of transformation in Oregon, they are subject to some key limitations. First, results in this report are intended to reflect baseline measurements, but transformation has been occurring for some time in Oregon. Thus, these are not true baseline measures, but rather a point-in-time of a partially-transformed system against which we can measure future progress.

Second, although we do compare sectors in terms of their scores, it is worth noting that our unit of analysis is *organizations*, and so scores are based on a relatively small number of data points (103 organizational respondents in all). Differences between sectors should be interpreted in the context of these small numbers.

Finally, our data are self-reported, and such data are always subject to potential bias. We surveyed a key informant at each organization — usually the chief executive or a similar senior official — about broad transformation activities, but a given respondent’s knowledge of what was actually going on within each transformation domain may not always be perfect.

COMMUNITY INVOLVEMENT IN GOVERNANCE

OVERALL OREGON
2015 SCORE

5.8

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Community engagement is a key element of linking health care more closely to community needs. A traditional health care system might have some ways to get community input, but voting power is held, and decisions are made, by health care executives. A more transformed system will empower community representatives from outside health care with agency, giving them a meaningful role in decision making around strategies, priorities, and the allocation of health care resources.

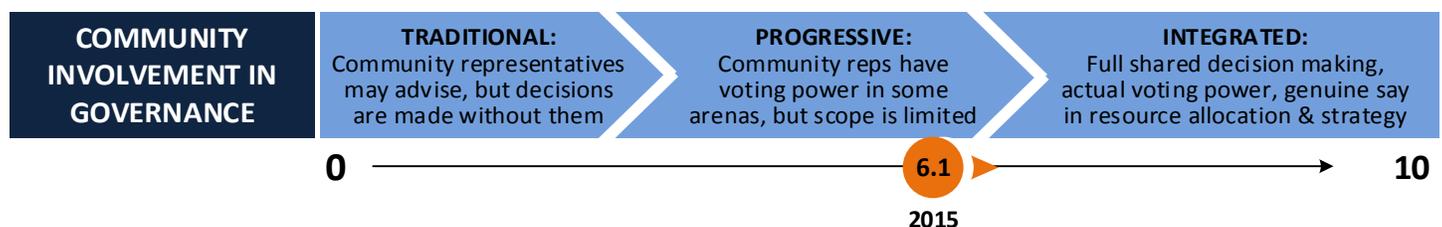
WHAT WE FOUND

Payers averaged a score 6.7 out of 10, with individual results ranging from 1.7 to 10. Providers averaged 6.0 out of 10, with individual results ranging from 0.0 to 10.

CCOs and FQHCs exhibited the strongest overall community engagement scores.; the Community Advisory Council requirements embedded in the CCO legislation may be a primary driver of this advance. Managed care plans averaged one point behind CCOs in terms of overall community involvement, though many indicated plans to expand in this area. Hospitals and physician groups were also less likely to have made significant progress.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	6.7	7.2	6.2
Uses feedback from members or consumers (0-2)	1.6	1.6	1.6
Uses feedback from at large community residents or laypersons (0-2)	1.0	1.1	1.0
Community members involved in organizational strategy or vision (0-2)	1.2	1.4	0.9
Community members involved in prioritizing community needs (0-2)	1.3	1.5	1.0
Community members help allocate funds for new programs (0-2)	1.2	1.3	1.0
Plans for future expansion of community involvement (0-2)	1.8	1.7	1.9

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	6.0	5.0	4.7	8.3	5.6
Uses feedback from members or consumers (0-2)	1.3	1.2	1.0	1.7	1.3
Uses feedback from at large community residents or laypersons (0-2)	1.1	1.2	0.8	1.2	1.0
Community members involved in organizational strategy or vision (0-2)	1.1	0.7	0.8	1.9	1.0
Community members involved in prioritizing community needs (0-2)	1.2	0.8	1.0	1.9	1.1
Community members help allocate funds for new programs (0-2)	0.9	0.6	0.6	1.8	0.7
Plans for future expansion of community involvement (0-2)	1.6	1.5	1.4	1.7	1.8



CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

COMMUNITY INVOLVEMENT IN GOVERNANCE

KEY FINDING: ROOM TO GROW

We asked what community involvement in governance looked like. Many delivery systems have some form of patient advisory panels or feedback loops that offer the community a voice. These feedback vehicles looked very different depending on the type of organization queried: traditional health plans wanted feedback on satisfaction from members to ensure an ongoing business relationships, while county-owned hospitals include community members on their governance board.

KEY FINDING: WORKING TOWARDS AUTHENTICITY

Many respondents described having a vehicle for soliciting feedback, but there still appears to be a gap between authentic governance participation and the current process. For health plans, the motivation for gathering data on the patient experience from member perspective is about staying competitive in the market. For other providers, the “community” of feedback is considered to be local non-health care leadership, not patients; one hospital told us that patients have a voice in “operational changes that impact care from the patient perspective.” Thus, the extent to which the community voice actively enters into actual decisions remains highly varied.

VOICES FROM THE FIELD

PAYER: *We're highly driven by the competitive nature of the business that we're in. It costs a lot of money to bring on a new customer so once you have them, you want to retain them. We're constantly looking to get feedback from our members on our programs and services.*

HOSPITAL: *We're a separate healthcare district so our elected board of seven people provides us with a lot of feedback from the county population. We also have the patient advisory group that meets monthly to talk about concerns, what they heard, and what services they'd be interested in. We hold community meetings and give everybody free hamburgers (laughs) and ask them what they think of the health district and what they want from it. We come to these events prepared to discuss and receive feedback from an involved community.*

HOSPITAL: *For our strategic planning, we involve representatives from all of the different political groups to look into what we should be focused on for the next year, three years, and five years. With the hospital being a big employer we need to take a lead in getting the groups together and having the conversation. We also have an advisory committee made up of community members with various backgrounds that meets six times a year to provide input and feedback.*

SEMINAL CASES:

A HOSPITAL INVITES THE COMMUNITY IN

HOSPITAL: Our structure is a system governance, and the members on our board of directors are all community members except for the CEO of the health system. Those community members are a combination of physicians, business leaders and your average citizen, who drive the strategies for the organization—they are a voice of the community. That would be one example of how we incorporate community feedback into the transformation and direction our health system is headed. At a more grass roots level, at our hospital we've had a patient advisory council for about four years now; these are past patients who, on a monthly basis, we work with to work on structural, operational changes that really impact the care from a patient's perspective.

CROSS-SECTOR PARTNERSHIPS

OVERALL OREGON
2015 SCORE

6.1

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Effective inter-organizational collaboration is a key element of accountable care. Under health care transformation, we expect that partnerships between delivery-system partners (hospitals and primary care, for example) will be cultivated to improve outcomes. A more progressive system will look beyond the system to include organizations that serve the population from other sectors (like housing) to incorporate social determinants of health; a transformative system will be driving that collaboration upstream.

WHAT WE FOUND

Overall payers averaged a score 6.5 out of 10, with individual results ranging from 1.7 to 10. Providers averaged 6.5, with individual results ranging from 1.0 to 10.

CCOs and FQHCs were the most transformative when it comes to building cross-sector partnerships. CCOs and FQHCs have a large Medicaid base, with entities serving a broader patient mix—health plans, hospitals, and physician groups — scoring the lowest. However, there appears to be a certain amount of spread within some aspects of cross-sector partnership building: scores around incorporating feedback from social service organizations and public health were relatively similar across all organizations, suggesting that the notion of creating partnerships with social service-type organizations that can work on population and social determinants of health is beginning to seep into the health care sector. CCOs are making the greatest strides when it comes to thinking of nontraditional partnerships, with payers and physician groups scoring the lowest.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	6.5	7.9	5.0
Uses feedback from providers in decision making (0-2)	1.7	1.9	1.5
Uses feedback from public health and social services in decision making (0-2)	1.3	1.6	1.0
Uses feedback from partners outside of health services in decision making (0-2)	0.9	1.2	0.5

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	6.5	5.7	6.8	7.3	7.0
Collaborates with public health to deliver whole-person care (0-2)	1.5	1.3	1.6	1.7	1.7
Collaborates with community groups to deliver whole-person care (0-2)	1.5	1.2	1.4	1.7	1.7
Uses feedback from providers in decision making (0-2)	1.5	1.6	2.0	1.7	1.2
Uses feedback from public health decision making (0-2)	1.1	1.0	1.4	1.4	1.1
Uses feedback from partners outside health care in decision making (0-2)	0.9	0.6	0.4	1.0	1.3



CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

CROSS-SECTOR PARTNERSHIPS

KEY FINDING: MAKING PROGRESS

Work that respondents described around cross sector partnerships was related to other transformation domains, like improving data-sharing capabilities across delivery systems, integrating care, and thinking more broadly about the social determinants of health. Despite low scores for organizations on this measure, there were examples of various organizations of partnering outside of healthcare sectors, particularly with schools. One organization described working with a school district as part of an initiative to set up a dental sealant program at a local schools. CCOs are doing more work connecting outside of the healthcare system, while other organizations indicated that “cross-sector partnership building” resembled strategic partnerships with other healthcare entities.

KEY FINDING: SPREAD, BUT WITHIN THE SYSTEM

Interviews revealed that most respondents were focused on building alliances *within* the healthcare system to retain a competitive edge; however, CCOs approached cross-sector partnerships from a broader perspective, looking to include social service organizations. There were a few examples of partnering with a non-healthcare entity, like a school, to bring preventative initiatives like dental sealing into schools as a way of reducing access barriers.

VOICES FROM THE FIELD

HOSPITAL: *We see that in order for us to remain independent years down the road, we probably will need to make more ‘strategic alliances.’ That means not billing ourselves out, but rather reaching agreements with larger systems to improve the referral process. An example: we reached an agreement with a group that has an implemented infrastructure of IT staff and servers that could provide the ongoing support needed for our system. The new system would provide a shared database so that when we refer patients we would have accurate information on what happened to them once they arrived at our facility. It’s not only just a financial arrangement, it also greatly improves patient care while allowing us to remain independent.*

PAYER: *We look at building strategic partnerships, but it’s more at the national level versus the community level. Building strategic partnerships is happening more robustly at broader levels. An example of that is we found a lot of our innovation comes out of our management of national account relationships. Typically, those large employers are more sophisticated and demanding so they have tendency to innovate more. One of the innovations that we implemented was focused on cardiovascular surgery patients that we found had multiple bouts of depression after they had a major cardiac event. We started an intervention that immediately after discharge, all of the follow-up visits are tele-video done in the convenience of the person’s home to avoid the stigma associated with going into a behavioral health provider’s office. The compliance rate or adoption rate of this program is very high. That’s an example of the type of innovations that we look at as a company that are scalable nationally.*

PROVIDER: *We don’t have a lot of community organizations involved; however, our stakeholders do, so in a sense there is strategic partnership building by extension—we work with our stakeholders who are working with community organizations.*

SEMINAL CASES:

A HOSPITAL WORKS WITH A SCHOOL DISTRICT ON DENTAL HEALTH

HOSPITAL: We wrote a grant and received funding to do planning for how we can put preventative dental care in the schools, working with three to five year olds to start. So at our organization, there’s a lot of work going on around dental health. We are beginning to see how you can at least start planning and thinking in terms of [these partnerships].

INTEGRATED & SHARED HEALTH CARE DATA

OVERALL OREGON
2015 SCORE

5.8

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Effectively sharing data is a key challenge of transformation – across settings of care, across provider groups and organizations, and across the traditional silos of physical, behavioral, and dental health. In a transformed system, we expect that providers can see data on each aspect of a person’s care, and that it will become easier for providers to see data about what happened when their patients got care in a different setting or from a different organization elsewhere in the community.

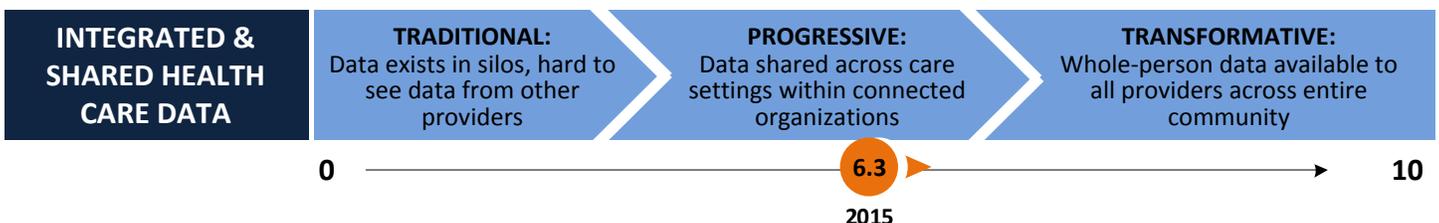
WHAT WE FOUND

Overall payers averaged a score 6.3 out of 10, with individual results ranging from 3.0 to 9.0. Providers overall averaged 6.2 with individual results ranging from 0.7 to 10.

Overall scores for all organizations were relatively similar, with widespread use of electronic records and integrating information within their organizations. Health plans and physician groups have the greatest capabilities around tracking chronic conditions, while FQHCS were the most advanced when it comes to integrating demographic data. Reverse integration (of chronic illness data into mental health organizations) was very limited and represents a slow-moving area.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	6.3	6.2	6.4
Integrates inpatient & outpatient data from providers within your organization (0-2)	1.7	1.9	1.4
Accesses systems for predictive risk stratification for patient populations (0-2)	1.3	1.3	1.3
Accesses registries to track chronic illness and preventative measures (0-2)	1.1	0.8	1.5
Accesses data on addiction services (0-2)	1.0	0.9	1.2
Accesses information on patients’ race, ethnicity & primary language (0-2)	1.1	1.2	1.0

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCS	Mental Health
OVERALL DOMAIN SCORE (0-10)	6.2	6.3	6.6	6.9	5.5
Amount of providers in organization that are connected via an EHR (0-2)	1.8	1.8	1.8	1.9	1.8
Integrates inpatient & outpatient data within organization (0-2)	1.5	1.7	1.4	1.5	1.3
Accesses systems for predictive risk assessment for patients (0-2)	0.5	0.6	0.8	0.6	0.2
Registries to track chronic illness and preventative measures (0-2)	0.9	1.1	1.6	1.3	0.3
Accesses data on addiction services (0-2)	1.0	0.7	1.0	0.9	1.4
Transmits prescriptions to pharmacies, confirms fill (0-2)	1.4	1.4	1.8	1.6	1.1
Accesses information on patients’ race, ethnicity & primary language (0-2)	1.6	1.5	1.0	1.8	1.6



CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

INTEGRATED & SHARED HEALTH CARE DATA

KEY FINDING: ROOM TO GROW

Though one physician group mentioned a handful of practices under their purview still working with paper records, most respondents described utilizing electronic health records to help with various metric reporting and to try and help providers make data-driven decisions around care management. Some delivery systems were having success sharing data internally, however sharing data across systems was described as a persistent challenge. Likewise, mental health organizations had the lowest score on the survey (5.5) and described lagging behind in this area because of the inability to link data from external systems.

KEY FINDING: THE CAPACITY ISSUE

Though the concept of data-driven decision making is spreading, several respondents indicated that the main barrier to leveraging this data was provider capacity to actually review and use it.

VOICES FROM THE FIELD

HOSPITAL: *We are working on sharing data, but the problem was we didn't have enough providers. We started to ramp up staffing in January 2014 when the Medicaid sign up started. We had three family practice doctors, two nurse practitioners, and two physician's assistants (PA). The nurse practitioners and PAs are all part time. We talked about outreach and managing segments of the population such as people with diabetes. We asked ourselves: how do you manage that population? Well, you have to have enough providers. We just signed another family practice doctor who's going to start with us, so we'll go from three providers to four. We are adding more staff so we can do more data work.*

PAYER: *We have an issue with providers having the capacity to review anything. There's a lot more information coming in than providers have time to review. We perform really well when it comes to getting the data if someone wants it, but a lot of providers don't know what to ask for or simply don't have time to read what they get, which is a constant struggle. There's not (particularly for smaller practices) anyone with five hours of freedom every week to understand information in order to do the best you can with things like certified risk scores and population health management tools. Time constraints are a constant issue.*

PROVIDER: *We have claims data and data from EMRs which helps us understand the cost measures for the quality of the care delivery and provides us information about diagnoses. In a majority of the cases the primary care provider does not have all the diagnoses of their patient. So if the patient was seen at a hospital and a new diagnosis was made, or they were seen at a specialist's office and a new diagnosis was made, not all of the necessary information reaches the primary care provider. However, all the information comes together once the claim is generated with that diagnosis. In order to help care coordination, we add that information to our claims and we do a monthly analysis of these claims, which creates a hybrid of data streams coming from the EMRs and claims.*

SEMINAL CASES:

HOSPITALS CONNECT TO OUTPATIENT DATA SYSTEMS

HOSPITAL: We have a single computer network between the two facilities in our community and we also have our own internal systems exchanging data. In other words, lab results from the hospital are populated in the clinic's patient record. The emergency doctors can bring up the clinic patient chart as well as the hospital patient chart in the ER so they have access to everything.

DATA FOR POPULATION HEALTH MANAGEMENT

OVERALL OREGON
2015 SCORE

4.5

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Improving population health is a pillar of both the Triple Aim and the Accountable Care model. To accomplish this, data-driven decision making on how to provide care is necessary. More traditional systems might not have access to this information, while more progressive systems might be using this type of data to help them with panel management. Ultimately, a transformed system will be using data to understand the needs of their patient population and the community, and investing in upstream initiatives.

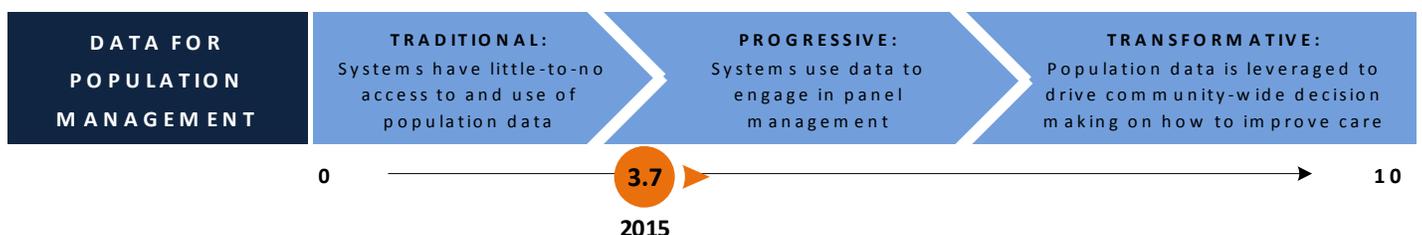
WHAT WE FOUND

Overall payers averaged a score 3.9 out of 10, with individual results ranging from 0.0 to 7.5. Providers overall averaged 3.8 with individual results ranging from 0.0 to 8.8.

This was the lowest scoring domain in our survey, suggesting that many organizations continue to struggle with key aspects of population health management. Data integration across silos—physical, mental, and dental, appears to be a challenge, with most organizations indicating that it is possible, but not routine, for them to do so. Likewise, accessing and using data related to social determinants of health and the larger community (beyond patient panels) presents a challenge for all health care organizations.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	3.9	4.0	3.9
Integrates inpatient & outpatient data from providers outside your organization (0-2)	1.3	1.3	1.2
Accesses data on patients' physical, mental and dental health (0-2)	1.0	1.1	1.0
Accesses data on patients' food, transportation housing and other basic needs (0-2)	0.2	0.2	0.2
Accesses data on health needs of the larger community you serve, not just your patients (0-2)	0.6	0.6	0.7

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	3.8	3.9	2.0	4.8	3.3
Integrates inpatient & outpatient data from outside providers (0-2)	0.8	0.8	0.4	1.2	0.7
Accesses data on patients' physical, mental and dental health (0-2)	0.9	0.9	0.8	1.1	0.7
Accesses data on patients' basic needs (food, housing, etc) (0-2)	0.7	0.6	0.2	0.7	0.8
Accesses data on larger community you serve, not just your patients (0-2)	0.7	0.9	0.2	0.9	0.5



CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

DATA FOR POPULATION HEALTH MANAGEMENT

KEY FINDING: VARIABLE SUCCESS IN DATA USE

All qualitative respondents agreed that leveraging data is the key to population health management but there was variability in the level of sophistication. The current challenges in doing so revolve around connecting disparate data systems, which explains the low scores on the survey for this measure. In general, the larger organizations described more sophisticated systems and efforts—moving away from a reliance on claims and developing EHR systems that track patients in real time—while smaller organizations lacked the resources and capital to move as quickly in building these systems. Interviews suggest that national payers have far greater capabilities than local delivery systems or CCOs, but these capabilities are leveraged around population management as it relates to chronic disease panels instead of the larger community. Like with integrating data, provider capacity is a barrier to leveraging available data.

KEY FINDING: WORKING TOWARD IMPROVEMENT

Data for managing population health is a priority for all organizations; respondents made it clear that there is a lot of mobilization and effort around improving capabilities here. Traditional commercial payers described population health data as something that gives them a competitive edge when contracting with providers.

VOICES FROM THE FIELD

HOSPITAL: *I think data capabilities are probably one of our biggest gaps at this point.*

We're attempting to close the gap by putting systems in place that will allow us to have better data analytics, but right now we're limited to information we can pull out of our financial cycle as well as our clinical database. They're not necessarily connected, so you can see where your gaps are from a financial perspective, but you can't link that well with the outcomes from a quality perspective; this is an area where we need to continue to invest. We are doing some partnerships at a state level with an alliance and trying to put in a database that will allow for these reports and analytics to be provided to our hospitals and to have a comparative group in order to drive potential changes. I think everyone who is trying to transform recognizes that data and good, clean actionable data is a gap right now and we're all trying to figure out the best way to close that gap.

PAYER: *We not only have the reporting ability to look at patient populations who may need more intervention than others, we have a lot of predictive modeling regarding who is likely to have a high cost or who is likely to be hospitalized this year. I think we are getting better at this, and we've learned a lot through our ACO relationship, but I don't believe any payer should be doing population health management. We have really good health coaches and we get really good rates of people quitting smoking and losing weight, but we do it on a smaller number than a medical group could do. In a perfect world, the payers wouldn't have to have case managers, health coaches and management programs because it would be done through the physicians' offices. In some of our relationships, we are the most successful when our team that uses those analytics shares information with our provider partners. Together, they make decisions and they meet. Ideally, we would support them in a way that it could all happen in the provider office. Now, the gap I think we have yet to solve is it requires a lot of data transfer, which is hard for an office to manage. We can set up piles of reports, but I'm not sure they're always going to be gleaned for the pieces of information that need to be addressed for individual answers.*

SEMINAL CASES:

LARGE, NATIONAL PAYER MAKES SIGNIFICANT DATA INVESTMENTS

PAYER: We offer a care management platform. It incorporates claims data and clinic data like lab results and gets their algorithms to create care alerts that go out to members and physicians saying 'hey this is a forty year old female, she hasn't had a mammogram in three years' and the alert will go to the member and the provider. There's a whole host of other capabilities that the software has. Those are some of the assets that we can bring a relationship that are not traditional payer-provider.

INTEGRATED CARE MODELS

OVERALL OREGON
2015 SCORE

7.2

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

The coordinated care model in Oregon is intended to remove traditional silos and move health care systems toward “whole person care,” with physical, mental, and dental health managed in a comprehensive and integrated way across the population. A more transformed system will have increasingly sophisticated ways to provide contextually-informed care that takes into account all health needs, as well as the cultural, social, and economic factors that might impact outcomes.

WHAT WE FOUND

Overall payers averaged a score 7.7 out of 10, with individual results ranging from 1.0 to 10. Providers overall averaged 6.9 with individual results ranging from 0.0 to 10.

Though sharing data across physical, mental, and behavioral health was a challenge, organizations scored high (overall state score 7.1) on integrating care, with health plans and FQHCs leading payers and providers with scores of 8.0 and 8.7. This suggests that the push to move toward more integrated care—a major transformation priority in Oregon — is happening collectively across organizations and markets.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	7.7	7.4	8.0
Contracts directly with physical health care (0-2)	1.8	1.8	1.8
Contracts directly with mental health care (0-2)	1.6	1.4	1.8
Contracts directly with substance use care (0-2)	1.6	1.4	1.8
Contracts directly with dental health care (0-2)	1.1	1.1	1.2
Launched initiatives for better integration of physical, mental, behavioral & dental health (0-2)	1.6	1.7	1.4

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	6.9	6.2	6.6	8.7	6.5
Collaborates directly with mental health providers (0-2)	1.6	1.3	1.6	1.9	1.8
Collaborates directly with substance use providers (0-2)	1.4	1.0	1.5	1.6	1.8
Collaborates directly with dental health providers (0-2)	1.1	1.0	1.0	1.7	0.8
Adoption of PCPCH recognition by clinics within organization (0-2)	1.4	1.6	1.8	1.9	0.7
Adoption of culturally sensitive programs within organization (0-2)	1.4	1.3	0.8	1.7	1.4
Efforts toward co-location of physical, mental, behavioral dental (0-2)	1.4	1.3	1.2	1.8	1.4



2015

CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

INTEGRATED CARE MODELS

KEY FINDING: EVIDENCE OF INVESTMENT

All organizations are working toward better integration of physical, behavioral, and dental health. Many described investing in programs that either co-locate physical or mental health, or offer care coordinators or healthcare navigators that are based in primary care but plugged into patients' mental health needs. Organizations recognize that there is cost savings associated with integration; they identified behavioral health issues as being associated with the high-utilizing populations, thus better integrated care would lead to savings. Mental health organizations we talked to indicated that the state-level integration push has been a big driver of change and effort on the part of the physical health world to better integrate the two fields.

KEY FINDING: THE CHALLENGES OF INTEGRATION

There is agreement that integration is a necessary step forward, albeit for different reasons: providers acknowledge that doing so would improve quality of care, and traditional health plans see selling clients a single integrated insurance package as a boon to their business model. However, respondents noted that the system level barriers—from regulations around privacy to things like irreconcilable billing codes, often seem like an insurmountable challenge. Interviews also imply that there is a diffusion of responsibility as to where the burden of integration effort should fall: payers feel that the delivery system needs to integrate before it can change fragmented reimbursement models, while providers feel that they cannot integrate care without being able to change how they bill.

VOICES FROM THE FIELD

HOSPITAL: *We feel we have changed as a health district much quicker than our mental health provider locally and our dental provider locally. They're both capitated for Medicaid services and they were not staffed to take care of the hugely expanding population in the county. We brought this to attention, which may have been unwelcomed, but because of it we feel they are now being more responsive. We expect them to play at our level so which has not made us particularly popular, but we're getting responses, which is the whole point.*

PAYER: *From the business point of view, selling clients medical, behavioral, dental, and disability is an all in one platform that would be easy for a provider to deal with. We would love to offer that kind of product, however, we find out it's not that easy because there's firewalls between behavioral and medical. Somebody gets admitted to the hospital because they're acutely ill from alcohol, but then they can't get them out of the hospital into treatment, so now they're under behavioral instead of medical. The rules that we write for what benefits end up in what buckets make it really complicated for people to manage. It would be far simpler if all of the dollars went to the provider and they decided what to spend it in.*

SEMINAL CASES:

A HOSPITAL HELPS FUND A MENTAL HEALTH CRISIS CENTER

Hospital: Mental health comes up in every [redacted] needs assessment. We are funding a Crisis Center. The idea is it's going to be funded through mental health and county dollars. It has not been uncommon the last year to have someone living in our ER for a week or three or four days for mental health related issues. The two hospitals in our region have agreed to make it so that if the police are called, the police don't have to bring the person to the healthcare facility first and they can just take them directly to the Crisis Center. We'd have those horror stories where the police are holding someone in a cell and they need mental health care, not physical health care, but we have only had a hospital to take them to. This is an exciting step in mental health care.

BETTER COORDINATION OF CARE

OVERALL OREGON
2015 SCORE

7.2

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Coordinating care is a crucial response to integrating the fragmented healthcare system and achieving a workable model of accountable care. A traditional system might not coordinate with other providers at all, while a more progressive system will be focused on transitions of care, such as avoidable readmission and connection with primary care post-emergency department visits. A transformed system will be less reactive and more deliberate in regard to organizing patient care activities.

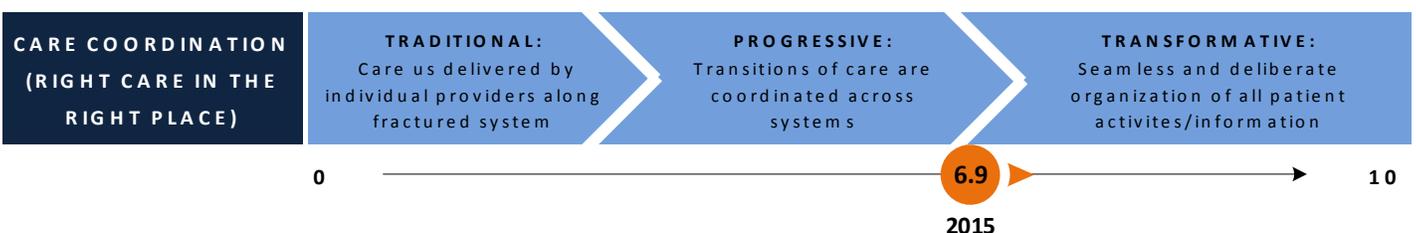
WHAT WE FOUND

Payers averaged a score 7.4 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 6.9 with individual results ranging from 0.0 to 10.

Health plans and FQHCs have the highest scores for care coordination (7.5 and 7.7), with mental health organizations scoring the lowest (6.5). There appears to be emphasis on efforts to spread the medical home model, improve care transitions, and focus on the high-utilizing patient population. However, there is less traction around contracting with nontraditional health care force— social workers or community health workers, for instance— to improve care coordination.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	7.4	7.2	7.5
Contracts with incentives for social workers or care navigators to provide better care (0-2)	0.7	0.7	0.8
Initiatives designed to encourage the spread of PCPCH's (0-2)	1.7	1.9	1.5
Initiatives designed for better care coordination for high utilizers (0-2)	1.9	1.8	1.9
Initiatives designed to improve access to care for your members (0-2)	1.6	1.5	1.8

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	6.9	6.7	7.0	7.7	6.5
Clinics within org. adopted programs that target specific patients (0-2)	1.5	1.5	1.2	1.8	1.3
Initiatives designed to create referral pathways between physical, mental, behavioral and dental health resources (0-2)	1.4	1.2	1.4	1.8	1.4
Initiatives designed to create better care transitions (0-2)	1.3	1.5	1.6	1.2	1.2
Initiatives designed to encourage appropriate utilization (0-2)	1.4	1.3	1.4	1.4	1.4
Initiatives designed to create other population health programs (0-2)	1.3	1.3	1.4	1.5	1.2



CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

BETTER COORDINATION OF CARE

KEY FINDING: MAKING AN EFFORT

Care coordination is common jargon in the healthcare transformation discourse, but interviews reveal that there are a variety of interpretations. Many conversations around the domain overlapped heavily with care integration and population health management, as well as discussions about how to leverage contracting relationships. Overall, care coordination programs are specifically aimed at target populations like high-utilizers. All respondents indicated that coordinating care is a strategic priority, but there is little uniformity in how they are attempting to reduce fragmentation.

KEY FINDING: CARE COORDINATION IS DEPENDENT ON DATA

Respondents understand care coordination as a pathway to improving quality and reducing cost, but doing so effectively requires the appropriate data pathways to identify patients and track them through the delivery system. One more transformed system (quoted on the right) with sophisticated contracting strategies for traditional services underscored that the lack of formal processes around agreements for information sharing with agencies that are not traditional health care is a challenge.

VOICES FROM THE FIELD

PAYER: *In their national model they set up what they call an “extensivist clinic.” They have doctors that are internists (who are generally formal hospitalists) and they have been able to show in a few markets they can reduce the cost of care for the 20% of the population that uses 50% of the resources by providing a concierge level of service to those members. They have methods using the EMR systems in data to identify them as high-cost patients based on diagnoses or diagnoses codes. They work really hard at coordinating the care for the 20% of the patients that bought 80% of the premiums. They’re about to get started in the fourth market in 2016, and they’re in discussions with us and some of the other health systems in the area to formalize those contracts in increments.*

PROVIDER: *What we’re trying to do is coordinate care for high utilizers and high-cost patients by coordinating the care being delivered at the provider level and clinic level with the information that is gathered at the health plan. We are trying to get information shared between the entities that are delivering care to these high utilizing and high-cost patients through the exchange of information any of these entities receives in regards to the change in the clinical settings of the patients. For example, any information upon being admitted in the hospitals needs to be shared with the primary care physicians so they can take action when the patient is discharged. Information on treatment received at the hospital and an attempt to get them back into the PCP office for a follow-up visit after that hospitalization can be used in order to find out why they were hospitalized for and then to manage them accordingly.*

SEMINAL CASES:

A PAYER USES CONTRACTING STRATEGY TO DRIVE CARE COORDINATION

PROVIDER: Most of our care is provided internally: we’ve got primary care, specialty care, hospital, dental, et cetera. Additionally, we contract for select services, so there’s some specialties that we’ll contract with for behavioral health. For those services that we do contract with, we set up arrangements with those contractor partners and build into those contracts ways to coordinate care together. When we start working with the outside agents then we have more diligence required around HIPAA. So as we’re beginning to, in all parts of our organization, reach out more and bring in new types of partnerships that’s one of the issues that we need to resolve. It’s more straightforward if you create a contract, for example, with a community health worker agency because there’s certain rules requiring business associate agreement to exchange information because they’re a paid provider. Some of the discussions and exchange of information between the more informal agencies is a bit more slippery.

PREVENTION & UPSTREAM CARE MODELS

OVERALL OREGON
2015 SCORE

6.3

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

The coordinated care model is designed to move resources and efforts upstream to improve population health through increased focus on prevention and the social determinants of health, like the impacts of the built environment and other structural realities like poverty. A traditional system might allocate most of their resources towards acute treatment, but a transforming system would progress towards allocating the majority of the resources for prevention and upstream interventions. The social determinants of health become increasingly more important as a focal point of community care and health strategies around prevention.

WHAT WE FOUND

Payers averaged a score 5.2 out of 10, with individual results ranging from 2.0 to 10. Providers averaged 7.2 with individual results ranging from 0.0 to 10.

Payers had consistent scores on prevention and SDH-informed care (5.2), with providers scoring higher (7.2) and FQHCs doing the most transformative work in this domain. Physician groups have the highest scores related to transformation associated with primary care, such as improved access to clinicians, medication management, and preventative care promotion, a positive outgrowth of the state's patient-centered primary care home initiative.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	5.2	5.2	5.2
Contracts with incentives for non-clinical patient needs such as food or housing (0-2)	0.5	0.6	0.4
Contracts with incentives for providers to reduce ED or hospital visits (0-2)	1.0	1.0	1.0
Initiatives designed for better integration with systems outside health care (0-2)	1.1	1.3	1.0
Initiatives designed for flex funds to support health engagement and lifestyle changes (0-2)	1.2	1.1	1.4
Initiatives designed to focus on health & prevention on the larger community (0-2)	1.3	1.3	1.4

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	7.2	6.5	8.3	7.8	7.4
Initiatives designed for referrals for basic patient needs (0-2)	1.2	0.9	1.0	1.4	1.4
Initiatives designed for medication management for at risk-patients (0-2)	1.5	1.3	1.8	1.5	1.8
Initiatives designed to improve access to clinicians (0-2)	1.6	1.5	2.0	1.8	1.5
Initiatives designed for preventative care promotion (0-2)	1.4	1.5	1.8	1.6	1.2



CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

PREVENTION & UPSTREAM CARE MODELS

KEY FINDING: A STRATEGIC PRIORITY FOR ALL

Delivery systems have mobilized around prevention; one self-insured entity described promoting wellness among employees, a hospital CEO indicated that his organization was doing extensive partnership with community-based wellness organizations, and national payers are working closely with employer clientele on specific preventative interventions like reducing depression after surgery. CCOs and delivery systems are sensitive to the role that social determinants of health play for their patient population. Community health worker initiatives, as well as the below-described effort to improve the health of a single patient with a lot of psychosocial barriers, was common.

KEY FINDING: PREVENTION MATTERS

Prevention is a focus across markets; we observed focus on social determinants is more limited to the Medicaid market, although one national payer noted that they have care coordination programs in their Medicare ACOs. Oregon CCOs have made tackling psychosocial issues a priority; for example, one hospital recounted an instance in which they used an empty room at their facility to care for a patient who required surgery and follow-up care but was having difficulty getting to appointments. The need for upfront investment to fund prevention initiatives, coupled with shortages in primary care are the key barriers standing in the way to making these initiatives successful and scalable.

VOICES FROM THE FIELD

HOSPITAL: *As an employer, we manage our own health insurance. In terms of physical health improvements and preventative care we want to improve the overall physical health of our employees. We've implemented a number of strategies around involving individuals in their health improvement through physical exercise, diet, and nutrition. We're trying to partner with other employers in the community to begin providing those types of incentives and programs for their employees as well. One of the initiatives that was sent out by the state of Oregon, and led by the former governor, was to move Oregon to becoming the healthiest state in the nation. We've embraced that initiative and we're hopeful that will continue and with the new governor's platform. We're taking on that initiative at a local level and we're partnering with the chamber, other businesses, school district, and the university to incorporate the concept, which will get at the improvement of the overall health of the community in terms of physical, spiritual, and mental health.*

SEMINAL CASES:

A HOSPITAL HOUSES A HIGH UTILIZER WHO CAN'T GET TO APPOINTMENTS

HOSPITAL: This scenario may sound amazing, but it's really not when you think about it: we had a morbidly obese person that couldn't even walk who needed some other types of surgery but couldn't get up because they were so overweight so we put them in the hospital in a vacant room for about two or three months. They had daily counseling, daily coaching from physical therapy, and from dietary. They lost a lot of weight, they got their surgery, and so on. When you think about it even though we're so called 'losing' two or three thousand dollars a day on that patient, the fact is we have to make room. Having them stay at the hospital probably cost us \$50 a day. We're able to do those kind of things that larger hospital systems just cannot. I think our ethics and our mission have to be in the right place. We also need to have a really good understanding of the finances because I hear so many people talk about how we can't do 'x' because we spend \$3000 a day on that patient, but that's not true. You have slack capacity, which is very inexpensive, and so we have a huge advantage in taking care of the high-utilizer patients.

WORKFORCE TRANSFORMATION

OVERALL OREGON
2015 SCORE

6.3

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Oregon in particular has championed the role of non-traditional health workers—such as social workers, community health workers, and care coordinators - in the advent of reform. A traditional system might still be relying on traditional care providers. As systems progress towards transformation, we expect that there will be expanded multidisciplinary focus that incorporates non-traditional, and non-clinical, roles such as community health workers or peer support networks to help address social determinants of health.

WHAT WE FOUND

Payers averaged a score 3.7 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 7.2, with individual results ranging from 0.0 to 10.

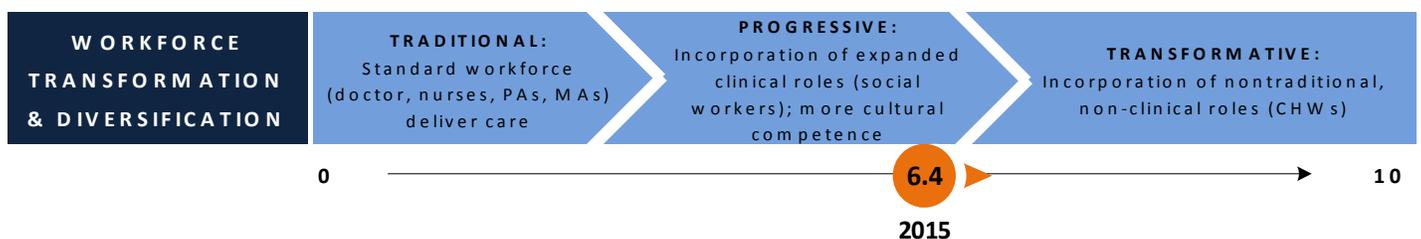
Overall providers overall scored much higher (7.2) compared to payers (3.7) in regard to workforce transformation. Among providers, FQHCs were doing the most transformative work around adoption of multi-disciplinary care teams and employing a non-traditional workforce. Providers appear to favor using a multidisciplinary and team-based care approach, however, employment of non-traditional workforces is still in rudimentary stages for providers other than FQHCs and mental health organizations.

RESULTS FOR PAYERS

	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	3.7	4.0	3.4
Contracts with incentives for having social workers to provide better coordinated care (0-2)	0.7	0.7	0.8
Contracts with incentives for having a non-traditional workforce (0-2)	0.6	0.8	0.5
Contracts with relaxed billing rules to allow providers flexibility to provide non-traditional healthcare services (0-2)	0.9	1.0	0.8

RESULTS FOR PROVIDERS

	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	7.2	6.3	5.0	9.1	7.0
Adoption of multidisciplinary, team-based care (0-2)	1.6	1.6	1.4	1.9	1.4
Employing non-traditional workforce (0-2)	1.3	0.9	0.6	1.8	1.4



CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

WORKFORCE TRANSFORMATION

KEY FINDING:

We observed workforce transformation taking place in two ways: the first involved promoting a model of team-based care that included non-clinical roles like social workers, and the other was introducing roles like community health workers to support providers. Non-clinical roles were recognized as being able to improve care delivery for patients and reduce the burden on primary care providers, particularly when these roles were used specifically for the complex patient population.

KEY FINDING: THE CHALLENGES OF “SPREAD”

Medicaid’s reimbursement for nontraditional health workers appears to facilitate workforce diversification for that market. One physician group secured a grant for a Community Health Care pilot program to better manage complex patients (regardless of payer). This program was well-received by physicians and patients alike, however, there was uncertainty about the sustainability of the role when grant funding ran out. There were examples of team-based care in other markets; for example, one payer described using team-based care for their older patient population. Outside of Medicaid, reimbursement for nontraditional healthcare workers might be thwarted by regulations around licensure: one payer noted that to formalize a community health worker role could threaten NCQA status because that worker would be considered “under-licensed.”

VOICES FROM THE FIELD

PAYER: *Using a model in population health, we’ve segmented into populations of ones, twos, threes, and fours. The fours are the people that might have a chance of dying within the next two years from an actuarial standpoint. In 2014 this group has mainly been a geriatric population. One of the first things we did was to use team-based care model and the medical home model to provide the best possible care tailored to this population.*

HOSPITAL: *One thing that we have done outside of the CCO is hire certified social workers to work in our clinics. So much of what people are dealing with are addictions and they are not willing to go to any kind of center because of the stigma associated with it, but they are willing to work with our social workers at our clinics, which is working out very well.*

PAYER: *We are definitely finding a way to align care coordinators and care managers in the clinic as the health plan and as a hospital. We have touch points at each of those locations whether it be an discharge nurse at the hospital with a report, a care manager that’s looking at chronic conditions of patients or the primary care provider offices. We are starting to feel alignment in conversations between the three groups of people. I think that’s one of those partnerships and engagement areas sections where we are to see those conversations happen and we are starting to see people leverage those different areas of outreach. We have community health workers, Promotorres and outreach teams, and then within the clinics we’ve got the population management nurses that are making all those reminder calls and doing all of the follow up work.*

SEMINAL CASES:

A DELIVERY SYSTEM PROMOTES TEAM-BASED CARE

HOSPITAL: Complex Care Medical Home was the last rung in the ladder for our medical home model, so we’ve been on this journey for the last five years. It’s pretty much implanted in the buildings. We’re certified in all our medical office buildings and we’re really using that platform to transform. We are now taking it one step further to transform how we deliver care by using a team-based approach by incorporating a pharmacist, social worker, navigator (which is non-clinical) RN, physician and behaviorist.

OWNERSHIP OF RISK

OVERALL OREGON
2015 SCORE

4.2

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Risk shifting - or moving away from a transactional financial reimbursement model—represents a radical shift in the way providers are incentivized and is hypothesized to be an important lever in reducing costs. In a traditional system, insurers own the risk and providers operate as fee for service. As the system shifts, there might be a blended model with risk bearing entities. In a transformed system providers might own more risk, and by doing so will work to provide effective care more efficiently.

WHAT WE FOUND

Payers averaged a score 4.5 out of 10, with individual results ranging from 1.3 to 10. Providers averaged 4.4, with individual results ranging from 0.0 to 10.

CCOs and physician groups/IPAs have the highest scores for ownership of risk (5.0 and 6.9), with FQHCs scoring the lowest (3.4). CCOs were more likely to share risk with providers, but health plans were not far behind.

Provider side risk takes several forms: we see an emphasis on contracts with withholds designed to incentivize quality, and a comparative de-emphasis on contracts with bundled payments around care episodes or other risk arrangements. Physician groups were generally more likely to see these quality withholds than FQHCs, hospitals, or mental health organizations.

RESULTS FOR PAYERS

	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	4.5	5.0	4.0
Contracts with risk shared by the care providers (0-2)	1.2	1.4	1.1
Contracts with bundled payments around care episodes (0-2)	0.6	0.6	0.6
Contracts with case rates for care providers (0-2)	0.9	0.8	0.9
Contracts with provider withholds to incentivize quality (0-2)	0.9	1.1	0.6

RESULTS FOR PROVIDERS

	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	4.4	3.9	6.9	3.4	5.4
Contracts with risk for bundled payments around care episodes (0-2)	0.5	0.5	0.5	0.5	0.7
Contracts with withholds designed to incentivize quality (0-2)	0.9	1.0	1.6	0.7	0.9
Contracts with other kinds of risk arrangements not mentioned (0-2)	0.4	0.2	1.4	0.3	0.5
Proportion of patients covered by risk-based contracts (0-2)	1.3	1.1	1.6	1.0	1.6

OWNERSHIP OF RISK

TRADITIONAL:
The payer manages the risk

PROGRESSIVE:
Risk borne by an entity consisting of delivery systems and payers

TRANSFORMATIVE:
Providers bear and manage most of the risk

0

4.5

10

2015

CONTEXT

FROM THE
QUALITATIVE INTERVIEWS

OWNERSHIP OF RISK

KEY FINDING: ROOM TO GROW

Respondents acknowledged that their organizations were, on some level, discussing and enacting strategies to move away from fee for service payment models, with the exception of mental health and FQHCs (as one FCHQ put it, they were too overwhelmed to do anything other than *react* to payment reform). Most of the transformational traction was associated with upside risk and incentives—discussed in further detail on the alignment of incentive and values page. A few respondents described having their providers at downside risk; in one case this model pre-dated CCO legislation; another delivery system mentioned experimenting with bundled payments for certain services.

KEY FINDING: THE CHALLENGES OF “SPREAD”

The spread of payment reform is hindered in some areas by penetration and whether or not there is a large enough population to move away from a fee for service model to something more transformative, like capitation.

VOICES FROM THE FIELD

HOSPITAL: *The CFO for the Oregon region said ‘don’t you dare do a capitated model on anything with Medicaid’ because we don’t have a big enough population.*

PAYER: *We don’t have any ACOs operating in commercial marketplace in Oregon and we do not have much managed care penetration in this marketplace, so Medicaid is really our test for commercial managed care.*

HOSPITAL: *Everything is kind of up in the air, so while theoretically everyone says we need to move to capitated models and we need to help out the population, getting from point A to point B is really painful. What I have found is that people are good at A and they’re good at doing things in B, but most people aren’t really the change agent to move you from point A to point B. I think that’s where we’re all kind of feeling our way into by being creative.*

SEMINAL CASES:

A CCO/PAYER PUTS PROVIDERS AT DOWNSIDE RISK

PAYER: Most of our primary care providers take risks, our behavioral health providers have excessive risk, our hospital system is at risk, but our specialty providers are not. By referring to ‘at risk’ I mean both upside and downside risk. It means there’s an opportunity to make money and an opportunity to lose money. The same upside and downside risk is true for the CCO, prior to events contracted to the state. We have the opportunity to gain money and lose money, so being at risk is a concept the community has embraced fully and is working on. At risk also means everyone’s contracts are a little bit different because we’re testing different methods of alternative payment.

INTEGRATED RISK MODELS

OVERALL OREGON
2015 SCORE

4.6

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

Risk shifting represents a radical shift in the way providers are incentivized and is hypothesized to be an important lever in reducing costs. In a traditional system, insurers might own risk, but often for only one portion of a person's total care – dental or mental health may be carved out or otherwise expected, for instance. As the system shifts, there might be a blended model, with organizations at risk for the entire range of a person's care. More transformed models might also create risk around population health markers, rather than just outcomes for attributed patient populations.

WHAT WE FOUND

Payers averaged a score 6.6 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 4.1, with individual results ranging from 0.0 to 10.

Health plans scored significantly higher (8.5) on integrated risk compared to the other organizations, with the next closest being physician groups (5.3) and FQHCs (2.4) being the lowest scoring. Payers scores for each of the domains are relatively similar, with direct risk for dental health being the lowest. Payers also scored relatively the same on each of the domains, with the range being within 0.2 for the three domains.

RESULTS FOR PAYERS

	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	6.6	4.6	8.5
Direct risk for physical health care (0-2)	1.5	1.1	1.9
Direct risk for mental health care (0-2)	1.4	0.9	1.8
Direct risk for substance use care (0-2)	1.4	0.9	1.8
Direct risk for dental health care (0-2)	1.1	0.8	1.3

RESULTS FOR PROVIDERS

	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	4.1	3.9	5.3	2.4	5.5
Contracts with risk for physical health care (0-2)	0.8	1.0	1.6	0.7	0.5
Contracts with risk for mental health care (0-2)	0.9	0.6	0.4	0.4	1.7
Contracts with risk for care your patients get in a different setting (0-2)	0.7	0.6	1.2	0.4	1.1



INTEGRATED RISK MODELS

KEY FINDING: ROOM TO GROW

Overall, respondents indicated that integration from the financial perspective was a challenge; mental health organizations felt that they had very little capacity to be forward thinking about better integration with physical health. One payer indicated that from their perspective, better integration of physical and behavioral health is outside of their desired scope and would have to happen at the delivery system level.

KEY FINDING: THE CHALLENGES OF REIMBURSEMENT

The most transformational example of risk integration was happening at the CCO level, with other payers prioritizing these types of efforts less. As with integrating data, challenges were systemic: issues reimbursing across silos were described as an obstacle to spread.

VOICES FROM THE FIELD

MENTAL HEALTH : *The whole system has changed so much, especially in the drug and alcohol world. It used to be that the state would award your agency some state-funded beds. Thereby, your job was to make sure that you had met the utilization and that those state-funded beds were full with individuals covered by Medicaid. You didn't necessarily have to worry about payment because you turned in your utilization report to prove that they were full or not full and how they were used. Now with CCOs and funding in the local communities, we have found there's a lot more of an authorization process that has to happen with each one of those contracts and there is no uniformity between the CCOs.*

PAYER: *We offer the full suite and behavioral health is embedded in all of our products as a medical benefit. I can't think of an example of where behavioral health is carved out. It used to be that there were national behavioral health vendors that had pretty decent penetration with employers, like larger employers. It was a standalone benefit through a standalone vendor or separate vendor. Today, it's almost always integrated into medical benefits, and so the downstream integration of behavioral health would happen with the delivery systems because from a benefit design, it's all integration.*

HOSPITAL: *As you probably heard numerous times, there are challenges in accessing mental health and dental health and there are difficulties around the reimbursement side of these two areas, which creates issues on the overall health of the population perspective, particularly your low income citizens. On the mental health side, our corporation is the only provider of inpatient mental health services and the work is expanding, particularly with the customer to be seen as a regional resource for those services. While we're not reimbursing at the level we need to sustain that, we also know that it is a benefit to our communities and the broader healthcare system so we're continuing to figure out how can we sustain those services and do that not only for now but for the long term.*

SEMINAL CASES: A CCO INCENTIVIZES INTEGRATION

PAYER: *We incentivize collaboration across physical, mental, and dental health. Sometimes it goes as well as you want, sometimes it goes better than you want, but we incentivize collaboration. We have a community governing part and that's why we developed contracting metrics that partners collaborate on and share. It would be a problem if we sat in a room and talked about every cost pack together, but ...our funding goes back into the community, and that gets more people interested in participating.*

ALIGNING INCENTIVES & VALUE

OVERALL OREGON
2015 SCORE

4.4

(0-10 scale)

WHAT IT IS & WHY WE MEASURE IT

The one of the hopes for accountable care organizations is that they will address the widely accepted notion that health care inflation is based on fee-for-service (FFS) payment methods. FFS is the status quo, and changes in financing that incentivize value over volume are an important element of transformation. A system moving to value will reward quality, while a transformed system might replace FFS with pay for performance or full capitation.

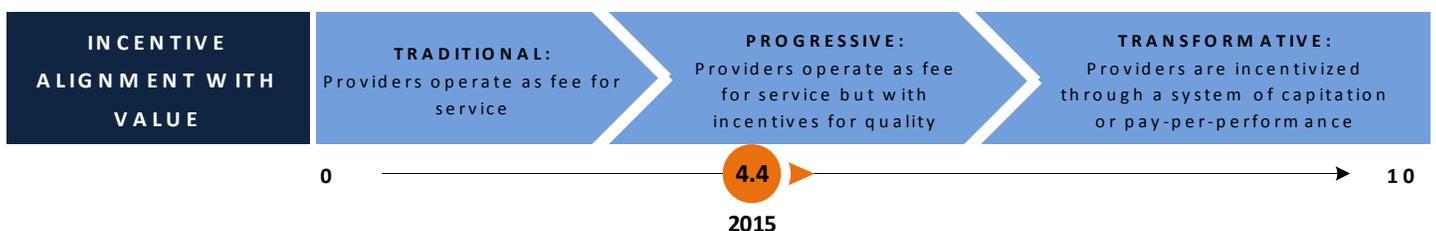
WHAT WE FOUND

Payers averaged a score 4.9 out of 10, with individual results ranging from 0.0 to 10. Providers averaged 4.2, with individual results ranging from 0.0 to 9.0.

Almost all organizations have made some effort to align financial incentives with good outcomes (like quality, prevention, and reduction in emergency department use). CCOs and other payers appear to making strides to build in cost reductive and population health management incentives into their provider contracts. Physician groups in particular scored highly on measures associated with aligning financial incentives with prevention and reducing costly utilization.

RESULTS FOR PAYERS	ALL PAYERS	CCOs	Health Plans
OVERALL DOMAIN SCORE (0-10)	4.9	4.6	5.3
Contracts with incentives for providers to reduce ED or hospital visits (0-2)	1.0	1.0	1.0
Contracts with incentives tied to population health metrics rather than clinical care (0-2)	1.0	0.8	1.1

RESULTS FOR PROVIDERS	ALL PROVIDERS	Hospitals	Physician Groups	FQHCs	Mental Health
OVERALL DOMAIN SCORE (0-10)	4.2	4.1	6.2	4.3	3.7
Risk-based contracts with Medicaid (0-2)	1.5	1.3	2.0	1.2	1.8
Risk-based contracts with Medicare (0-2)	0.6	0.8	1.8	0.4	0.5
Risk-based contracts with Commercial/Private(0-2)	0.5	0.8	1.3	0.2	0.4
Contracts with incentives for clinical quality performance (0-2)	1.0	1.0	1.4	1.3	0.7
Contracts with incentives for integration of care (0-2)	0.6	0.7	0.2	0.6	0.6
Contracts with incentives for reducing ED or hospital visits (0-2)	0.8	0.7	1.4	1.1	0.6
Contracts with incentives for screenings or other preventive care (0-2)	1.0	0.9	1.4	1.2	0.7
Confidence in the quality of the outcomes used for incentives (0-2)	1.1	1.0	1.2	1.3	1.1



ALIGNING INCENTIVES & VALUE

KEY FINDING: MAKING STRIDES

When asked about the types of incentive alignment efforts organizations were taking on, qualitative respondents identified value based care as a common strategy. Payers and Physician groups described building pay-for-performance into their contracts. Providers were also taking on more contracts that incentivized value-based care, although we observed that from their perspective, the amount of reporting required was often frustrating and overwhelming.

KEY FINDING: THE CHALLENGES OF “SPREAD”

Interviews suggest that the barrier to spread in this domain is largely associated with the providers working on the ground, who are disincentivized by pay for performance contracts, even if they are willing to do the work around improving quality. One care delivery system argued that vertical integration is the best solution, because salaried doctors are more receptive to working under the population health improvement model. Another payer noted that contracting for value was more about building transparent relationships with providers.

VOICES FROM THE FIELD

HOSPITAL: *We wanted to make sure that we were all going in the right direction and all the “kumbaya” stuff was more important to all of us than the financial stuff, which is also how the contracts were read for the doctors. Unlike most, the employment contracts with the physicians are almost exclusively salary based and very little performance based. This was at the providers request because they felt like if it was a heavy performance based contract, something like ‘you must see ‘x’ number of patients every week.’ We had this conversation last week in the middle of health reform and discussed that if you have a performance based contract with the doctors, they don’t want to do outreach and they don’t want to do patient education, they don’t want to go to meetings about population health and the like because it’s cutting into their income. If they’re salary-based, they’re willing to do that and they say that’s why they went into medicine in the first place, to make people well. Basically, performance based contracts with doctors can be a disincentive to do health reform.*

PAYER: *I think when people start looking at volume to value, it starts to sound like the capitation of the early 90’s, which it’s really not. I think where we are in the journey is half of the battle is not what should the contract pay and what are we going to pay you. From my point of view, half the battle is if can we build a collaborative relationship and work together to the same goals so that at the end of the year when we’re doing a reconciliation of what the spend was, it’s completely clear to you why you’re getting a certain portion of the savings, and there are no surprises why you don’t.*

SEMINAL CASES: A CCO/PAYER INCENTIVES INTEGRATION

HOSPITAL: Yes. We’re working with our payers and in our negotiations as we’re moving forward with renewals or even new payment contracts, we are incorporating different models than we would have likely incorporated a number of years ago. Areas where we’ve got more risk, so we would for instance put a portion of our payments at risk for up-coming measures like quality service, cost efficiency but this is a new area from where we would traditionally function in contract negotiations with the payers. A lot of the work that we’re seeing now as being effective in models are around the CCOs because the CCOs seem to be more open and versed in those types of relationships. However, we’re starting to see that when we’re engaging with local employers and their insurance providers and providing health services for the local employers, we’re starting to put outcome measures into those payment structures.

APPENDIX

This document outlines a proposed measurement system for the SIM grant’s assessment of the “spread” of transformation elements within and beyond CCOs in Oregon.

DOMAINS: WHAT ARE WE TRYING TO MEASURE?

Previously, the SIM workgroup identified a set of “domains” of transformation along which we would measure progress over the course of the study. Here, we propose a slightly simplified set of domains, along with a proposed system for measuring progress along those domains over time.

Our domain scores are best seen not as *performance scores* — our intent is to avoid making assumptions about what any organization *should* be doing. Rather, the scores are best seen as representing the *density* of given transformational elements within the health care system — how much of certain things are present across the system at a given point in time. Thus, for example, a score in the domain of *integrated care models* represents the density of such initiatives across the system, not the performance of any given organization against some standard of practice.

OVERVIEW OF PROPOSAL

We propose a mixed methods assessment framework that can be applied either with or without an intensive qualitative layer:

SURVEYS: Our proposed framework is built primarily off of a pair of surveys — one aimed at payers, the other at provider organizations — which will be delivered via mail or online to key industry executives and representatives. These surveys are designed to capture high-level data on organizational progress along a series of dimensions mapped to the transformation domains. Organizations contribute “points” to transformation domain scores by answering questions certain ways, and the number of points created within a domain tell us about the density of those elements across the system. We will track how this density changes over time.

QUALITATIVE SUPPLEMENTS: For each of our transformation domains, we have also identified a series of supplemental qualitative questions that could be added to contextualize each domain of inquiry. These questions are explicitly designed to add context and understanding to the domain scores, but to be *optional* in terms of the objective scoring. Thus, they are best used to characterize the exact nature of each organization’s work in a given domain. They can also be used to help identify new areas of transformation that should be added as items to future iterations of the survey or other potential improvements to the tool.

FIELDING: We propose fielding the surveys with a large number of organizational representatives, but selecting a subset of those organizations (from both within and outside of CCOs) to add the qualitative supplement.

SCORING: Every survey item contributes information to one or more of our domain scores, and each domain score is a function of responses to multiple survey items. We compute a “score” in each domain based on the answers we get; our average score across all respondents can be seen as an indication of overall density of transformational elements within a given domain across the system as whole. In our proposed tool, scores in a given domain change when organizations do one of two things: launch new initiatives or elements identified as transformative, or spread existing transformation elements more broadly across their organization. Thus, the scoring gives “credit” for trying more things, but also for picking fewer things and implementing them more widely. Our ultimate goal is to score progress along each of our transformation domains, then track changes in scores over time.

GOALS: Our goals by the end of the grant period include the following:

- ◆ To track the “density” of transformation over time across our domains by administering the quantitative tool multiple times across the study period;
- ◆ To understand the shape and nature of transformation efforts using the results of the qualitative supplements; and
- ◆ To use results from both efforts to improve and refine the tool, leaving OHA with a tool that can be deployed after the grant with minimal additional qualitative effort.

TRANSFORMATION DOMAINS

The SIM workgroup originally identified 16 *transformation domains* that would define an organizations’ potential movement toward a more transformed system. This proposed measurement system would create a tool for assessing and scoring organizations along those respective domains.

Here, we propose a simplification of the original domains, combining some into broader domains and splitting others to better distinguish between distinct elements of transformation. We propose capturing data within a total of 11 domains. The following table summarizes the relationship between the original and newer proposed domains; our domains are described in greater detail starting on page 14.

ORIGINAL DOMAIN(S)	NEW DOMAIN NAME	DESCRIPTION
GOVERNANCE & COLLABORATION		
Community Involvement in Governance	Community Involvement in Governance	Measures degree to which community members are actively engaged in the organization’s governance and decision making.
Partnerships & Joint Initiatives	Cross-Sector Partnerships	Measures degree to which health care organizations partner across sectors (with public health, social services, or other interconnected systems that fall outside traditional health care).
DATA & INFORMATION SHARING		
EHR Adoption and Use	Integration & Sharing of Health Care Data	Measures how organizations access and share health care data, including physical, behavioral, and dental. Covers both the ease of sharing and the scope of data they are able to share.
Data for Population Management	Using Data for Population Management	Measures how data is actually <i>used</i> , in particular, whether data is accessed and/or used that moves beyond traditional clinical care and speaks to upstream or population health approaches.
CARE DELIVERY TRANSFORMATION		
Integration	Integrated, whole-person care models	Covers integration of physical, behavioral, and dental care.
Pharmacy & Medication Management; Site of Care; Care Coordination; Access; Cultural Competency	Better Coordination: Right care in the right place	Covers efforts to better manage care, including improving access, coordinating care to reduce unnecessary visits, or other efforts designed to optimize the efficiency of care delivery
Prevention; Models of Care	Prevention and SDH-informed care	Covers efforts to build upstream activities and thinking into health care, including prevention or population health efforts or care models informed by the social determinants of health.
Workforce	Workforce transformation and diversification	Covers attempts to diversify or broaden the health care workforce to meet a broader array of patient needs, either through non-traditional or multidisciplinary care or improved competency meeting the needs of diverse patient populations.
RISK & REIMBURSEMENT		
Ownership of risk	Ownership of risk	Refers to the proximity of risk to the point of care — whether providers are at “downside” risk for outcomes.
n/a	Integration of risk	Refers to the <i>types</i> of risk organizations bear, and the degree to which that risk cuts across the various dimensions of “whole person care.”
Incentive Alignment with Value; Redistribution of incentives	Aligning incentives and value	Refers to attempts to incentivize population health or other value-based care or services via “upside risk” for providers (bonuses or other incentives tied to transformation).

MAPPING & SCORING

A. MAPPING OF SURVEY QUESTIONS INTO DOMAINS

We have identified 11 domains of transformation we would like to measure. We propose mapping each question on the survey into one or more domains. Each domain will then receive a score based on the combination of responses to the items contributing to those domains, and we can track that score over time to observe the progress of transformation.

There is certainly room for interpretation about how items contribute to domains, and we do not necessarily picture a mutually exclusive approach — domain scores should be the result of distinct combinations of items, but individual items could contribute

	PAYER SURVEY QUESTIONS	PROVIDER SURVEY QUESTIONS
GOVERNANCE & COLLABORATION		
CROSS-SECTOR PARTNERSHIPS	8ADE (3)	6DE, 11ADE (5)
COMMUNITY INVOLVEMENT IN GOVERNANCE	8BC, 9ABC, 10 (6)	11BC, 12ABC, 13 (6)
DATA & INFORMATION SHARING		
INTEGRATED & SHARED HEALTH CARE DATA	6AEFHI (5)	7, 8AEFHJ (7)
USING DATA FOR POPULATION MANAGEMENT	6BCDG (4)	8BCDG (4)
CARE DELIVERY TRANSFORMATION		
INTEGRATED CARE MODEL (PHYS, BEH, DENTAL)	2ABCD, 7B (5)	6ABC, 9AD, 10B (6)
BETTER COORDINATION; RIGHT CARE IN RIGHT PLACE	4A, 7ACG (4)	9E, 10AEGI (5)
PREVENTION & SDH-INFORMED CARE	4BD, 7DEF (5)	10CDFH (4)
WORKFORCE TRANSFORMATION & DIVERSIFICATION	4AC, 5 (3)	9BC (2)
PAYMENT & FINANCE		
OWNERSHIP OF RISK (PROXIMITY TO POINT OF CARE)	3ABCD (4)	1DEFG, 2 (8)
INTEGRATED RISK	1ABCD (4)	1ABC (3)
ALIGNING INCENTIVES & VALUE	4DE (2)	3ABCD, 4ABCD, 5 (9)

B. SCORING OF ITEMS

Every survey item has three responses representing the spread or breadth of that element across an organization, ranging from not much at all (on the right of the scale) to widely present or integrated across the organization (on the left of the scale).

We propose that each answer contribute a number of points toward an organization’s transformation score in the domains to which that question contributes, with the least transformed answer providing 0 points (no progress toward transformation) and the most transformed answer providing 2 points.

SCORING EXAMPLE (FROM PROVIDER SURVEY)

4.	How easy is it for care providers in your organization to get or share the following kinds of information on your patients?		
	Easy or routine	Possible, but not routine	A significant challenge
A. Share data with other providers in your organization to coordinate care	0	0	0
SCORE	2	1	0

In this example, a provider organization that answers “possible, but not routine” would gain 1 point toward its transformation score in any domain associated with item 4A. In our proposed crosswalk, item 4A on the provider survey is associated with the “integrated and shared health care data” domain, so the organization would receive 1 point

C. SCORING OF DOMAINS

SCORING EXAMPLE (FROM PROVIDER SURVEY)

We propose that each organization receive a total “transformation score” for each domain, composed of the sum of the points accumulated across all the items that contribute to that domain.

WHAT SCORES MEAN: By design, scores of a 0 are intended to mean that relatively little of that transformational element is present in the organization. A score of 1 indicates presence, but with limitations (with something in place only via pilots or in a limited number of sites), while a 2 represents widespread adoption throughout the organization.

Organizations that have not accomplished any meaningful milestones in a given dimension would have a net score of 0, representing a more traditional health care organization. It is important to note that transformation scores are not intended to imply value judgments about an organization’s optimal choices in the face of transformation, nor do they necessarily represent how good a job they are doing or otherwise reflect “performance.” Rather, they are a simple way to assess spread and depth of specific transformative elements the SIM workgroup identified as markers of transformation.

HOW SCORES MOVE: Scores are a function both of how many *different* elements an organization is pursuing within a given domain (represented by the number of different items within a domain where the organization scored at least one point), and also the degree to which elements have *spread* through the organization (represented by the numerical score on any given item). Thus, organizations can earn “points” toward transformation either by launching or piloting new ideas and elements, or by working to increase the spread of an existing idea or element across the organization.

POTENTIAL WEIGHTING: Because we are trying to avoid making judgments about which approaches “should” be seen in any given organization or community, we propose weighting each transformation element equally and conceptualizing scores as a construct representing the density of transformational elements rather than an assessment of performance or progress. However, it would also be possible to weight elements within domain scores differentially. For instance, if some elements are seen as particularly crucial to transformation in a given domain, they could be up weighted in the computation of the domain score. For now, we propose not weighting domain scores, at least until a round of data is available and the SIM team can assess the tool’s performance in capturing key elements of transformation and discriminating between more and less transformed entities.

POTENTIAL STANDARDIZATION OF DOMAIN SCORES: Our eleven domains consist of between three and seven items, each with a range of responses that can contribute 0-2 “points” toward a domain score. Value ranges for our domains will thus range from 0-6 (for a three item domain) to 0-14 (for a seven item domain).

4. How easy is it for care providers in your organization to get or share the following kinds of information on your

	Easy or routine	Possible, but not routine	A significant challenge
SCORING	2	1	0
D. Access data on patients’ food, transportation, housing, or other basic needs	0	0	X
E. Access data to track your performance on key quality improvement outcomes	X	0	0
G. Data about health needs in the larger community you serve, not just your patients	0	X	0

TOTAL DOMAIN POINTS: 3

In this example, a provider organization receives 3 points (out of a possible 6 *points*) in the transformation domain of using data for population management (items 4D, E, and G on the provider survey tool).

The final score for any domain across the entire sample of organizations (or a specified subsample of organizations) will be the average domain scores of all participating organizations.

To move its score, this organization could either introduce new pilots around access to basic needs data (moving item D from 0 to 1) or work to spread its use of data on health needs in the community (moving item G from 1 to 2). Thus, scores can be improved either by trying new initiatives or working to spread/improve existing pilots and models.

D. TRACKING TRANSFORMATION & SPREAD

To track transformation and spread across Oregon, we will compute at each assessment point the average domain score (representing the average of all organizational scores in a particular domain of transformation), as well as the average domain score for distinct subsets of organizations (including CCOs, non-CCO payer organizations, non-CCO provider organizations, and other groupings as requested). We will then track transformation scores over time.

Because domain scores will be computed as the average scores from a set of surveys within any given subset of organizational respondents, we can compute standard errors for each score and test changes in domain scores over time for statistical significance.

The data will have the greatest value not as assessments of any individual organization, but as a summary snapshot of the “density” of transformation elements present within any given domain across a given sector of the health care landscape.

E. QUALITATIVE DATA

We have created optional qualitative supplements for each domain on each of our instruments. These open ended questions are intended to solicit more detailed information on the type, nature, and utility of transformation efforts (as opposed to the presence or spread of them within an organization), as well as the particular challenges or successes of an organization’s efforts.

We do not anticipate that the qualitative supplement will be administered to every respondent. Instead, we propose selecting a purposive subsample of respondents about whom the SIM team hopes to collect deeper or more nuanced information, then administering the qualitative questions as a supplemental, semi-structured interview with key leaders from that organization. We would then transcribe, code, and analyze that data for key themes and common elements that can inform our quantitative assessment.

This data would serve two key purposes. First, it would be used to contextualize transformation efforts within key industry partners or organizations, as well as providing lessons learned that could help other organizations who are working on similar transformation goals. Second, it can help improve the quantitative assessment tool by identifying areas of transformation activity the tool is either not asking about or capturing with insufficient nuance. This would allow for future iterations of the tool to be improved to capture these elements, creating a more responsive assessment system that can react to changes in the shape of transformation as it unfolds in Oregon.

TRACKING EXAMPLE: DOMAIN SCORES OVER TIME

DOMAIN: USING DATA FOR POPULATION MANAGEMENT

	First Assessment	Second Assessment	Third Assessment
All Organizations (N=XXX)	2.4	2.8	3.4
CCOs (N=XXXX)	2.6	2.8	3.5
Non-CCO Payers (N=XXX)	2.2	2.7	3.2
Non-CCO Providers n=XXX)	2.4	2.8	3.4
Regional Subgroup (N=XXX)	2.4	2.7	3.4
Other Subgroup (N=XXX)	2.4	2.8	3.0

SCORES RANGE FROM 0-6.

In this hypothetical example, scores for a variety of different organizational groupings are compared over time for the domain “using data for population management.” Scores represent the average domain score for all organizations in that particular category.

Because scores are computed based on averages from a sample of respondents, standard deviations can be computed and scores can be tested for significant change over time.

Organizations can be grouped into bundles of interest (by type, by geography), and scores can be recomputed for any given bundle to allow for tracking of overall transformation and transformation within any given subset of the data.

SIM QUALITATIVE GUIDE

PAYER VERSION

GENERAL

- Please describe your organization. How many lives do you cover? What types of products do you offer?
- How familiar is your organization with the coordinated care model?

RISK

- Is your organization at risk for all elements of a person's health — physical, mental, behavioral, and dental?
- If not, how does your risk profile impact the ability of your organization to respond to a person's overall care needs?

CONTRACTS

- How do your contracting relationships impact your ability to improve coordination of care across the silos — physical, mental, behavioral, dental?
- If you don't contract directly with a given type of provider, but you want to coordinate better with them because what they do impacts your members, what are your strategies?
- What are your view on networks?

PAYMENT STRUCTURES

- Tell us more about the specific payment reforms you are working on?
- What other kinds of payment reform that aren't listed here might help improve care? Is your organization working on developing or piloting these?
- What kinds of payment reform ideas might help improve population health across a community, rather than just improving clinical care?

NON TRADITIONAL REIMBURSEMENT

- Are there other agreements or services you are purchasing that fall outside of traditional health care reimbursement models?
- If your organization isn't working toward reimbursement of non-traditional workforces, what are the key barriers you are facing in doing so?
- If you could (or do) incentive providers around population health metrics, what sort of measures do you use? Have you faced resistance from those providers?

DATA AND INFORMATION SYSTEMS

- When you want to develop an improvement system or program, how hard is it to put together all the data you need to do it right? What are the main barriers?
- Is the data you have really actionable? How easy is it to share with providers and other partners, and how often do they actually use it?
- In addition to sharing data across silos of health care, what are the barriers to sharing data beyond health care — for instance, with social service, corrections, public health, or other connected systems?
- Do you have any way to see data on the basic needs of your members — food, transportation, housing, and so on? If you could, how would you use that data to help transform care for your members?

SIM QUALITATIVE GUIDE

PAYER VERSION, CONTINUED

TRANSFORMATION SYSTEMS

- Tell us more about the specific transformation initiatives or programs you are working on as an organization? Which are your highest priorities?
- Are there other important transformation initiatives we haven't captured?
- What are the key barriers you've faced in launching and/or spreading transformation initiatives?
- Are providers usually on the same page with these initiatives, or do they sometimes create friction? What are the main sticking points?
- Are you working on any initiatives that try to connect health care to connected systems outside of health care (such as corrections, social services, and so on)? What do those look like, and what are the challenges you've faced in launching them?

PARTNERSHIPS AND ENGAGEMENT SYSTEMS

- Has your organization developed any new strategic partnerships over the last 3 years?
- What does engagement and feedback with these groups look like in your organization? How is that feedback collected, and who "presents" it in your meetings?
- Who decides whether feedback is incorporated or not into a decision? Who communicates that decision back to the stakeholders, if they aren't already present?
- What kinds of decisions are most important for you to engage with stakeholders? Are there decisions where your organization would prefer to act without that engagement?

COMMUNITY INVOLVEMENT

- How did (or do) you find the community members who serve in your organization? Are they connected to partners you work with?
- If community members vote or otherwise actively participate in decisions, how much of the total "vote" do they represent? Are they just one or two votes out of many, or a significant proportion of the total votes?
- Are there specific times or issues where community members don't attend meetings or vote, even if they are typically part of your board or governing structure? What characterizes those times?

CONCLUSION

- We discussed how your organization has been changing. All told, what would you define as the motivation behind making these changes?

SIM QUALITATIVE GUIDE

PROVIDER VERSION

GENERAL

- Please describe your organization. What types of clinics are within your umbrella? What is your patient mix?
- How familiar is your organization with the (or coordinated care) model?

RISK

- How are you working toward incorporating payment reform into your practices? How are risk, incentives, and payments changing?
- How much risk does your organization and the practices within it take on? How meaningful is the financial impact?
- How does your risk profile impact the ability of your organization to respond to a person's overall care needs?
- What about patients taking on more risk/consumer engagement in care?
- Tell us more about how your organization feels about/is responding to the call for payment reform?

COLLABORATION

- How do your contracting relationships impact your ability to improve coordination of care across physical, mental, behavioral, and dental health?
- If you don't contract directly with a given type of provider, but you want to coordinate better with them because what they do impacts your patients, what are your strategies?

DATA AND INFORMATION SYSTEMS

- How actionable is your data? How easy is it to share with providers and other partners, and how often do they actually use it?
- In addition to sharing data across silos of health care, what are the barriers to sharing data beyond health care — for instance, with social service, corrections, public health, or other connected systems?
- How does your organization use data to tackle any or all of the following: population health, preventative care, or social determinants of health?

MODELS OF CARE

- How are you using team-based care/the medical home model to improve population health?
- What is your strategy around the medical home model among clinics under your organizational umbrella?
- What kinds of efforts are clinics undertaking to improve cultural competency?
- How are you working towards improved care integration or better "whole person" care, and what role is payment reform playing in that?

TRANSFORMATION SYSTEMS

- Tell us more about the specific transformation initiatives or programs you are working on as an organization? Which are you highest priorities?
- What are the key barriers you've faced in launching and/or spreading transformation initiatives?
- Are providers usually on the same page with these initiatives, or do they sometimes create friction? What are the main sticking points?
- Are you working on any initiatives that try to connect health care to connected systems outside of health care (such as corrections, social services, and so on)? What do those look like, and what are the challenges you've faced in launching them?
- Do you have concerns about provider shortages at your organization? How are you ensuring that patients have access to providers when they need the?
- Are you working on any initiatives to try and reduce high-cost utilization (like ED visits) in favor of primary care? What do those look like, and what are the challenges you've faced in launching them?

SIM QUALITATIVE GUIDE

PROVIDER VERSION, CONTINUED

PARTNERSHIPS AND ENGAGEMENT SYSTEMS

- Has your organization developed any new strategic partnerships over the last 3 years?
- What does engagement and feedback with these groups look like in your organization? How is that feedback collected, and who “presents” it in your meetings?
- Who decides whether feedback is incorporated or not into a decision? Who communicates that decision back to the stakeholders, if they aren’t already present?
- What kinds of decisions are most important for you to engage with stakeholders? Are there decisions where your organization would prefer to act without that engagement?

COMMUNITY INVOLVEMENT

- How did (or do) you find the community members who serve in your organization? Are they connected to partners you work with?
- If community members vote or otherwise actively participate in decisions, how much of the total “vote” do they represent? Are they just one or two votes out of many, or a significant proportion of the total votes?
- Are there specific times or issues where community members don’t attend meetings or vote, even if they are typically part of your board or governing structure? What characterizes those times?

CONCLUSION

- We discussed how your organization has been changing. All told, what would you define as the motivation behind making these changes?

HEALTH CARE TRANSFORMATION

TRACKING SURVEY

—PROVIDER VERSION—

This survey is designed to collect information about your organization's journey through health care transformation. Please give your best estimate in response to each question, and skip any questions you aren't sure how to answer.

We're collecting this data in order to catalogue the different ways health care organizations are responding to transformation. We aren't rating organizations against each other in terms of performance; instead, the intent is to understand and monitor the overall transformation landscape in Oregon.

YOUR RISK ARRANGEMENTS

1.

In how many of your contracts with payers does your organization bear the following types of financial risk?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Risk for physical health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Risk for mental or behavioral health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Risk for care your patients get in a different setting (such as the ED)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Bundled payments around care episodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Withholds designed to incentivize quality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Other kinds of risk arrangements not mentioned here	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. What proportion of your patients are covered by a risked-based contract?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2.

What proportion of your patients are covered by a risked-based contract?

- All or nearly all (>50%)
- Some, but not all (1%-49%)
- None (0%)

3.

What type of payers comprise your risk-based contracts? Select all that apply.

	Most or all of our risk based contracts (>50%)	Some of our risk-based contracts (1%-49%)	None of our risk based contracts (0%)
A. Medicaid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Medicare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Commercial/Private	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. NA/No Risk based contracts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

INCENTIVE STRUCTURES

4.

In how many of your contracts with payers does your organization have a chance to qualify for the following kinds of incentive or bonus payments?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Incentives for clinical quality performance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Incentives for integration of physical, mental, and behavioral health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Incentives for reducing ED or hospital visits by your patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Incentives for screenings or other types of preventive care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5.

How confident are you that the quality and clinical outcomes used to determine the incentives are accurate?

- Very confident
- Somewhat confident
- Not at all confident

COLLABORATIONS

6.

Do you or your organization collaborate or partner directly with the following types of service providers in order to provide better whole-person care?

	Yes, Extensively	Yes, in small or Limited Ways	No
A. Mental health care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Substance use care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Dental health care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Public health or social service agencies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Community groups or advocacy organizations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

DATA & INFORMATION SYSTEMS

7.

How many of the care providers in your organization are connected via an electronic health record?

- All or nearly all (>50%)
- Some, but not all (1%-49%)
- None (0%)

8.

How easy or routine is it for care providers in your organization to get or share the following kinds of information on your patients?

	Easy or routine	Possible, but not routine	A significant challenge
A. Integrate outpatient and inpatient data from providers within your organization?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Integrate outpatient and inpatient data from providers outside your organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Access data on all aspects of a patients' health—physical, mental, & dental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Access data on patients' food, transportation, housing, or other basic needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Access sophisticated systems for predictive risk assessment and risk stratification for patient populations?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Access registries to track chronic illness and preventative measures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Access data about health needs in the larger community you serve, not just your patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Access data on addiction services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Transmit prescriptions to pharmacies and confirm whether they have been filled electronically?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
J. Access to information on patients' race, ethnicity, and primary language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

MODELS OF CARE

9.

Have clinics within your organization adopted any of the following models of care?

	Yes, all or nearly all	Yes, some	No
A. Patient Centered Primary Care Home (PCPCH) recognition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Multidisciplinary, team-based care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Employing non-traditional workforce (community health workers, peer support, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Culturally sensitive care programs or initiatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Programs focused on targeting a specific group of patients (high utilizers, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

OTHER TRANSFORMATION INITIATIVES

10.

Has your organization launched any provider-level initiatives or efforts designed to do any of the following?

	Yes, large scale or major efforts	Yes, some pilots or small efforts	No
A. Referral pathways between physical, mental, behavioral, and dental health resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Co-location of physical, mental, behavioral, and/or dental providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Mechanism for referrals for basic patient needs (e.g. food, housing, transportation)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Medication management for at risk patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Programs to better manage care transitions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Efforts to improve access to clinicians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Programs to encourage appropriate utilization among your patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Preventative care promotion initiatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Other population health focused initiatives or programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PARTNERSHIPS & ENGAGEMENT

11.

How often does your organization's governing body partner with or meaningfully incorporate feedback from the following communities into its decision making?

	Most deci- sions include this feedback	Some deci- sions include this feedback	Few or no decisions include this feedback
A. Physicians and/or other direct care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Patients who get care in your organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. At large community residents or laypersons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Public health or social services agencies/groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Partners outside health services, like education or criminal justice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

COMMUNITY INVOLVEMENT

12.

How extensively are patients or at-large community members involved in your organization's actual decision making?

	They have meaningful voting power	They discuss & participate, but don't vote	Their feed- back may be solicited, but no direct role
A. Decisions about organizational strategy or vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Decisions about which programs or efforts should be prioritized	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Decisions about how funds are allocated for new programs/initiatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13.

How would you describe your organization's future plans in terms of community involvement in governance and decision making?

- We want to expand community involvement
- We're happy with the way things are now
- We want to reduce or minimize community involvement

HEALTH CARE TRANSFORMATION

TRACKING SURVEY

—PAYER VERSION—

This survey is designed to collect information about your organization's journey through health care transformation. Please give your best estimate in response to each question, and skip any questions you aren't sure how to answer.

We're collecting this data in order to catalogue the different ways health care organizations are responding to transformation. We aren't rating organizations against each other in terms of performance; instead, the intent is to understand and monitor the overall transformation landscape in Oregon.

YOUR RISK PORTFOLIO

1.

Thinking about your products, how often does your organization bear **direct risk** for the following types of care?

	Most or all of our products (>50%)	Some of our products (1%-49%)	None of our products (0%)
A. Physical health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Mental health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Substance use care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Dental health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

YOUR PROVIDER CONTRACTS

2.

Does your organization contract directly with any of the following types of service providers?

	Yes, Extensively	Yes, in small or limited Ways	No
A. Physical health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Mental health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Substance use care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Dental health care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

YOUR PAYMENT STRUCTURES

3.

How often do your provider contracts include the following types of payment elements?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Meaningful risk shared by the care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Bundled payments around care episodes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Case rates for care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Provider withholds to incentivize quality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NON-TRADITIONAL REIMBURSEMENT

4.

How many of your provider contracts include incentives or direct payments for providing any of the following types of services?

	Most or all of our contracts (>50%)	Some of our contracts (1%-49%)	None of our contracts (0%)
A. Social workers or care navigators to provide better coordinated care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Enabling services for non-clinical patient needs such as food or housing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Non-traditional workforces, like community health workers or peer support networks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Incentives for providers to reduce ED or hospital visits for patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Incentives tied to population health metrics rather than clinical care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5.

For your contracts that don't formally allow payment for non-traditional healthcare services, how often are billing rules relaxed to allow providers flexibility to provide these services?

Frequently Occasionally Never

DATA & INFORMATION SYSTEMS

6.

How easy or routine is it for you to get or share the following kinds of information on your members or beneficiaries?

	Easy or routine	Possible, but not routine	A significant challenge
A. Integrate outpatient and inpatient data from providers within your organization?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Integrate outpatient and inpatient data from providers outside your organization	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Access data on all aspects of a patients' health—physical, mental, & dental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Access data on patients' food, transportation, housing, or other basic needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Access sophisticated systems for predictive risk assessment and risk stratification for patient populations?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Access registries to track chronic illness and preventative measures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Access data about health needs in the larger community you serve, not just your patients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Access data on addiction services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Access to information on patients' race, ethnicity, and primary language	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

TRANSFORMATION INITIATIVES

7.

Has your organization launched any initiatives or efforts designed to do any of the following?

	Yes, large scale or major efforts	Yes, some pilots or small efforts	No
A. Encourage the spread of patient-centered primary care homes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Better integration of physical, mental, behavioral, and dental health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Better care coordination for high priority or high utilizer members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Better integration with connected systems outside health care (social services, housing, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Flex funds or other programs to support health engagement & lifestyle change	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Health & prevention initiatives focused on the larger community, not just your own members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Improve access to care for your members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. Health initiatives to reduce disparities for populations such as race, ethnicity, location (rural vs urban), etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PARTNERSHIPS & ENGAGEMENT

8.

How often does your organization partner with or meaningfully incorporate feedback from the following communities into your decision making?

	Most decisions include this feedback	Some decisions include this feedback	Few or no decisions include this feedback
A. Physicians and other care providers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Members or consumers of your products	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. At large community residents or laypersons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Public health or social services agencies/groups	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Partners outside health services, like education or criminal justice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

COMMUNITY INVOLVEMENT

9.

How extensively are consumers or at-large community members involved in your organization's decision making?

	They have meaningful voting power	They discuss & participate, but don't vote	Their feedback may be solicited, but no direct role
A. Decisions about organizational strategy or vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Decisions about which community needs should be prioritized	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Decisions about how funds are allocated for new programs/initiatives	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10.

How would you describe your organization's future plans in terms of community involvement in governance and decision making?

- We want to expand community involvement
- We're happy with the way things are now
- We want to reduce or minimize community involvement

Sustainable Healthcare Expenditures Workgroup CHARTER

Authority

In a June 2013 letter, Governor Kitzhaber asked the Oregon Health Policy Board (OHPB) for recommendations to better align Oregon’s implementation of the Affordable Care Act and spread the triple aim goals—better health, better care, and lower costs—across all markets. In addition to other items, the letter charged OHPB with providing recommendations which would move the marketplace toward “growth rates of total health care that are reasonable and predictable.”

In response, OHPB recommended in December 2013 that the Oregon Health Authority (OHA) and Oregon Insurance Division (OID) establish a workgroup to establish a methodology for calculating annual total health care expenditures.

Membership

The workgroup members are appointed by the Commissioner of OID and the Director of OHA. The workgroup should include and/or consult with stakeholders representing consumers, business, government, insurers, and providers.

Responsibility

The workgroup is charged with providing input to OHPB on the design and implementation of a methodology for calculating annual total health care expenditures at various levels, including statewide, regional, and the individual health care entity. Some of the key topics the workgroup should consider include:

- Which expenditures should be included or excluded from the calculation?
- Which types of health care entities should be tracked?
- How should expenditures be adjusted for health status or population?
- What are the most appropriate data sources?
- Are there data gaps or additional data that need to be collected?
- What is a feasible timeline for the implementation of the methodology at each reporting level (statewide, regional, and individual health care entity)?

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

Principles

At a minimum, the workgroup should ensure that its recommended policies and methodologies are transparent, accurate, and feasible.

Timing/Schedule

The workgroup will hold meetings beginning in April 2014 and conclude in December 2014 or when OHPB determines that the charter has been fulfilled, whichever is sooner. The meeting sessions will serve as an opportunity for the workgroup to review and respond to proposals or alternatives that address the design and implementation considerations outlined in the Responsibility section above.

Staff Resources

Coordinator:

Mark Whitaker, Senior Financial Policy Analyst, Office of Health Analytics, OHA,
Mark.Whitaker@state.or.us, (503) 551-5489

Resources:

Gretchen Morley, Director, Office of Health Analytics, OHA

Russell Voth, Research and Data Manager, Office of Health Analytics, OHA

Lisa Angus, Director, Health Policy Development, Oregon Health Policy and Research, OHA

Gayle Woods, Senior Policy Advisor, Oregon Insurance Division

**Predictable and Sustainable Rate of Growth Workgroup
ROSTER**

Kraig Anderson
Senior Vice President & Chief Actuarial
Moda Health
Portland

Glenn Johnson
System Director of Reimbursement
PeaceHealth
Vancouver

Dean Andretta
Executive Director
Willamette Valley Community Health
Salem

Meg Niemi
President
SEIU Local 49
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Peter Davidson
Chief Financial Officer
PacificSource Health Plans
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Jesse Ellis O'Brien
Health Care Advocate
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Providence Health & Services – Oregon
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Greg Van Pelt
President
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Jon Hersen
Vice President, Care Transformation
Legacy Health
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Kelvin Wursten
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Denise Honzel
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Oregon Business Council
Portland



Sustainable healthcare expenditures for the state of Oregon December 2, 2014

Background

In the last several years, Oregon has engaged in efforts to transform the health care system, guided by the Triple Aim of better health, better care, and lower costs. In June 2013, the Governor tasked the Oregon Health Policy Board (OHPB) with developing strategies to better align Oregon's health system reform efforts and spread the triple aim goals across all markets. OHPB responded with a report outlining three key strategies:

1. Create system-wide transparency and accountability through a robust measurement framework, including a public-facing health system dashboard, which tracks the effect of ACA implementation and Oregon's health system reforms.
2. **Move the health care marketplace toward a fixed and sustainable rate of growth.**
3. Improve quality and contain costs by expanding an innovative and outcome-focused primary, preventive and chronic care infrastructure.

To implement the second strategy of moving toward a sustainable rate of growth, OHPB instructed the Oregon Health Authority (OHA) and the Oregon Insurance Division (OID) to create a workgroup to develop a sustainable rate of growth methodology for the total cost of care.

Sustainable Healthcare Expenditures Workgroup Process

The Sustainable Healthcare Expenditures Workgroup (SHEW) was chartered to recommend a method to compute health care expenditures. In April 2014, the OHPB instructed the SHEW to focus exclusively on the technical aspects of the calculations. The workgroup proceeded with the following charges:

The SHEW is comprised of members representing the Oregon Business Council, the Oregon Health Leadership Council, the Oregon State Public Interest Group, health insurance plans, and providers (see Appendix D). Members were appointed by the Commissioner of OID and the Director of OHA. The SHEW conducted five meetings between May and November 2014. The SHEW was charged with the following:

- Select elements to include or exclude from the expenditure calculation
- Identify appropriate data sources
- Comment on caveats, data gaps, and potential areas of improvement

OHA engaged John McConnell, Ph.D., Director of Oregon Health & Science University Center for Health Systems Effectiveness (CHSE) to formulate the expenditure methodology. The group reviewed expenditure efforts from other states, including Vermont, Massachusetts, and Maryland. By October 2014, the group reached a consensus on a calculation methodology focused on measuring spending. Dr. McConnell completed preliminary calculations (see Appendix A), with final calculations to be completed in December 2014.

This report outlines the methodology selected by the SHEW, as well as recommendations to implement the methodology.

Approach

The guiding principles for the SHEW's work include transparency, accuracy, and feasibility. There was also sentiment that existing data sources should be used and the methodology kept simple and practical. The group agreed to begin with a simple model using the OHA All-Payer All-Claims database and build from there to track population and per capita spending and assessment of impacts of population growth and coverage changes.

Given the OHA All-Payer All-claims database was identified as an existing source for calculating expenditures, the SHEW defined total health care expenditure is a measure of statewide spending from both public and private sources on provider-billed services. After much debate about the best approach, the committee decided not to attempt to calculate the true cost of delivering health care, as much of the needed information to compute costs is not readily available. Spending includes patient cost-sharing amounts such as deductibles and co-payments in addition to provider-billed services.

The overall approach includes using available data to construct estimates of per-member, per-month (PMPM) spending for relevant insurance groups. Then, use available data to estimate member months (or member years) in each group to calculate spending in per member and aggregate dollars.

The payer categories included in the estimate are:

- Medicaid
- Medicare – Fee-for-Service
- Medicare Advantage
- Commercial
- Veterans Health Administration
- Medicaid/Medicare dual eligible
- Uninsured

The Medicare population is broken into two categories due to the insurance options available to beneficiaries: Medicare Fee-for-Service and Medicare Advantage. In this measurement framework, Medicare Advantage members are part of the Commercial category, since private insurers administer the insurance product to the Medicare member.

Uninsured is listed as a payer category even though spending by uninsured individuals is not based upon insurance claims. Their spending is based on a different set of assumptions, which will be explained further in the next two sections. Even though the Uninsured group requires different calculations, the SHEW recommended that spending by this population should be calculated and tracked over time. The uninsured are significantly impacted by expanded health insurance coverage from the Affordable Care Act.

More detailed methodology information including data sources, exclusions, and caveats are included in Appendix A.

Results

The total healthcare expenditure measurement framework for Oregon is a work in progress. Preliminary results are available in Appendix A. These results will be updated and finalized in December 2014. Once

Cost vs. Spending

Cost refers to the actual expense of providing health care services, including supplies, labor, and overhead.

Spending refers to the amount paid for health care services. This includes payments by public and private insurers, as well as payments made by patients, such as co-payments.

the initial methodology is finalized, spending across multiple years (2011, 2012, and 2013) will be calculated to assess trends in health care spending across Oregon. Additional analysis could examine where spending is highest, drivers of spending, and possible impacts of health care transformation efforts. This tool is envisioned as one among many tools that can be used to measure transformation and inform health care policy decisions. The committee members had general consensus that focusing on claims spending is a credible and simple approach that represents the best that can be done with existing data sources. The committee expressed a need to track how changes in the health care payment landscape may affect calculations – for example, ICD10 conversion – and make adjustments as appropriate to the methodology or recommendations for use.

The current methodology excludes some aspects of expenditures in the health care market, including services that do not have readily available data sources and which likely do not represent large proportions of overall spending at this time. The committee members were largely comfortable with noting these existing exclusions, and currently there are no plans to incorporate these elements into the methodology. The following are excluded from the calculations:

- Settlement payments – payments resulting from litigation or other mediated processes
- Claims related to substance use are redacted in the All-Payer All-Claims database
- Wrap around payments related to Federally Qualified Health Centers
- Over-the-counter medications
- Alternative care such as massage, naturopaths not offered as a covered benefit
- Patient non-covered or non-submitted spending
- Workers compensation
- Other government programs (Indian Health Services, SAMSHA)

Assessment of next steps:

- Finalize expenditure methodology and source data, and validate estimates against other sources. This work is to be completed by December 15, 2014.
- Expand expenditure categories from payer-specific (Medicaid, Medicare Commercial, etc.) to patient-related descriptors such as pregnant women, non-pregnant adults, children, and infants for all payer categories.
- Add additional time periods so the calculations include expenditures from 2011, 2012, and 2013 to assess trend.
- Include new data components. The measurement framework currently excludes some data components because they were not readily available using existing data sources. The SHEW recommends that these data could contribute to the overall utility and accuracy of the measurement framework, and efforts should be made to examine the feasibility of incorporating some or all of the following and incorporate over time when possible:
 - ♦ Long-term care
 - ♦ Dental care
 - ♦ Vision care
 - ♦ Carrier administrative expense – net of health premiums collected and benefits paid, as well as net additions to reserves, profits, or losses
 - ♦ Medicare Part D Fee-for-Service
 - ♦ Non-claim based or flexible spending by private or public payers on member needs

Committee Recommendations

The SHEW recommends the following four strategies be implemented to refine and utilize the health care spending methodology with the long term goal of moving the health care marketplace toward a fixed and sustainable rate of growth:

1. To continue with a simple, transparent approach to measuring spending using available data sources while recognizing the limitations.
2. To continue working with Dr. McConnell and CHSE to complete and further refine the measurement framework. The target for CHSE is to have more complete calculations in December 2014 for the SHEW to review and provide input. The SHEW recommends an additional December meeting to review the final calculations.
3. To calculate health care spending for multiple years (2011, 2012, and 2013). Examine and describe any difficulties or inaccuracies in making year by year comparisons. Continue work on understanding caveats and validating estimates with existing known sources.
4. To provide clear direction regarding the purpose and use of the total health care expenditure calculations. There was strong consensus among SHEW members that the model is not yet ready for use to examine trends, set targets, or inform policy decisions. A clear mandate from OHPB to further the model would be needed to move the work forward and define a clear purpose.
5. To continue to engage stakeholder groups in discussions regarding use of the total health care expenditure model. The SHEW expressed concerns about how use of this model would impact various stakeholder groups, and identified a need to engage stakeholders in the process of determining appropriate uses for the calculation.

Contact Information

For more information on the Sustainable Healthcare Expenditures Workgroup, please visit:
<http://www.oregon.gov/oha/Pages/srg.aspx>

For questions or comments on this report, please contact Jeff Winkley at (971)673-2313 or jeffrey.winkley@state.or.us.

Office of Health Analytics

The Oregon Health Authority's Office of Health Analytics collects and analyzes data to inform policy development, program implementation, and system evaluation. The Office of Health Analytics supports OHA efforts to further the triple aim goals of improving health, improving health care quality and reducing costs by leveraging qualitative and quantitative data to monitor progress and identify future policy and program opportunities.

Appendix A: Methodology & Preliminary Estimates

Overall approach

The overall approach to spending involves multiplying an estimate of the population within each payer group by the estimate of spending for individuals within that payer category. As noted above, SHEW estimates will be computed into eight payer categories. As an example, total spending for the Medicaid category would consist of average monthly spending (per-member per-month spending, or PMPM) multiplied by 12 (to create average annual spending), multiplied by the total number of Medicaid beneficiaries. This approach is intended to retain simplicity in the presentation and also provide clarity around what is driving spending (such as population growth, increased utilization, or rising prices). Furthermore, SHEW estimates are separated into five cohorts: pregnant women, non-pregnant adults aged 18-64, infants (ages <1), children (ages 1-17), and adults 65 and over.

Note that spending is defined based on the payer perspective, and includes spending on health services paid for by the health plan or out of pocket by the individual.

Medicaid Encounter Data

A substantial portion of Medicaid claims are paid on a capitated or contracted basis, which results in a \$0 “allowed” amount in the claims record. Rather than ignoring these \$0 claims, the SHEW estimates calculate an average payment rate based on available fee-for-service payments for each CPT and DRG and attaches these prices to the claims, creating a “repriced” estimate that accounts for utilization that is recorded in claims but not paid directly through claims.

Data sources

Estimates for enrollment for each payer category were based on data from the following sources:

<u>Payer Category</u>	<u>Data Source</u>
Medicaid	OHA
Medicare Fee-for-Service	Centers for Medicare & Medicaid Services (CMS) summary public use files ¹
Medicare Advantage	Oregon All-Payer All-Claims database ²
Medicaid/Medicare Dual Eligible	Linked Medicaid data from OHA and Medicare data from CMS
Veterans Health Administration	Publicly available Department of Veterans Affairs data ³
Commercial	Oregon All-Payer All-Claims database
Uninsured	CHSE methodology using DCBS data and Kaiser Family Foundation estimates ⁴

¹ Excludes Part D pharmaceutical spending. Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html

² Information about Oregon All-Payer All-Claims database at: <http://www.oregon.gov/oha/ohpr/rsch/pages/apac.aspx>

³ Available at: <http://www.va.gov/vetdata/Expenditures.asp>

⁴ CHSE methodology at: <http://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/current-projects/upload/Impacts-of-the-Affordable-Care-Act-on-Health-Insurance-Coverage-in-Oregon.pdf>. Kaiser Family foundation estimates at: <http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/>

Each of these databases provides an estimate of total enrollment. We also compare enrollment numbers to data on enrollment from the Oregon DCBS. Note that DCBS reports show several categories not available in APAC; stop-loss only self-insured, and carriers who have fewer than 5 thousand covered lives.

Note that enrollment numbers are estimates of unique individuals and are not equivalent to “member years” of enrollment. An individual may be enrolled for less than a year if they transition into or out of a coverage category.

Caveats

The current approach does not include several categories of health care spending. These include, for example, “wrap around” payments, settlement payments or payments for quality improvement programs, over the counter medications, alternative care, a wide range of care that may not result in the submission of a claim or payment.

Preliminary Estimates

Table 1: Total spending estimate

Group	Members	PMPM	Total
Commercial*	1,970,794	\$268	\$6,338,073,504
Medicare Advantage	270,138	\$593	\$1,923,111,239
Medicare FFS	360,894	\$593	\$2,569,202,805
Medicaid	651,023	\$289	\$1,686,982,032
Duals (Medicaid)	35,626	\$833	\$277,201,464
Duals (Medicare)	35,626	\$824	\$274,020,608
Veterans Affairs	93,529	\$699	\$784,387,000
Uninsured	550,000	\$42	\$275,000,000
Total	3,967,630		\$14,127,978,652

*Commercial calculation uses estimates to capture spending for the individuals not included in APAC.

Table 2: 2012 Medicaid spending by cohort

Group	Medical PMPM*	Rx PMPM*	Medical + Rx PMPM*	Member Years	Total
Children <1 year	\$1,012	\$5	\$1,017	11,736	\$143,226,144
Children 1-18	\$93	\$14	\$107	336,001	\$431,425,284
Pregnant women	\$1,062	\$21	\$1,083	13,635	\$177,200,460
Non-pregnant adults <65	\$368	\$84	\$452	172,406	\$935,130,144
Total (weighted mean)	\$251	\$38	\$289	533,778	\$1,686,982,032

* Allowed amounts, re-priced

Table 3: 2012 Commercial spending by cohort

Cohort	Med PMPM*	Rx PMPM*	Med + Rx PMPM*	Member Years**	Total
Children <1 year	\$503	\$4	\$507	12,806	\$77,911,704
Children 1-18	\$108	\$11	\$119	342,103	\$488,523,084
Pregnant women	\$1,466	\$18	\$1,484	16,600	\$295,612,800
Non-pregnant adults <65	\$243	\$39	\$282	1,053,109	\$3,563,720,856
Adults 65 and older	\$297	\$99	\$396	90,673	\$430,878,096
Total (weighted mean)	\$233	\$35	\$268	1,515,290	\$4,856,646,540

*Paid (re-priced) and OOP

**Member years reflect medical enrollment; Rx PMPM estimates are likely understated

Table 4: 2012 Medicare Fee-for-Service spending

Group	PMPM	Member Years	Total
Under 65*	\$637	63,750	\$487,604,468
Over 65	\$584	297,144	\$2,081,598,337
Total	\$593	360,894	\$2,569,202,805

*Under 65 includes some duals, but not all (ESRD)

**Excludes Medicare Part D pharmaceutical spending

Table 5: 2010 Dual Eligible spending

Group	PMPM	Member Years	Total
Medicare	\$824	27,728	\$274,020,608
Medicaid	\$833	27,728	\$277,201,464
Total			\$551,222,072

Table 6: 2012 Veterans Health Administration medical spending

PMPM	Member Years	Total
\$699	93,529	\$784,387,000

Table 7: 2013 Uninsured medical spending

PMPM	Member Years	Total
\$42	550,000	\$275,000,000

*PMPM based on Kaiser Family Foundation analysis of out-of-pocket spending for uninsured individuals. Note that this is not an estimate of uncompensated care, charity care, or bad debt.

DRAFT

Appendix B: Governor's Letter to OHPB



JOHN A. KITZHABER, MD
Governor

June 3, 2013

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

Dear Chair Parsons and Vice-Chair Shirley:

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

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

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

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

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-6827
WWW.OREGON.GOV

Oregon Health Policy Board
June 3, 2013
Page Two

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

Sincerely,

A handwritten signature in black ink, appearing to read "John A. Kitzhaber". The signature is fluid and cursive, with the first name "John" being the most prominent.

John A. Kitzhaber, M.D.
Governor

MJB/smg

Appendix C: OHPB Final Recommendations, Strategy 2

Strategy 2: Move the marketplace toward a sustainable and fixed rate of growth

The goal of this strategy is to contain health care costs, to improve the affordability and sustainability of health care coverage, and improve Oregon's economic climate by measuring the true cost of the health care system. Oregon should formulate or endorse a sustainable rate of growth methodology aimed at containing and lowering the total cost of health care that includes, but is not limited to, costs for health care entities, individuals and health plans. OHA and OID should create a sustainable rate of growth workgroup that will develop an accurate and stakeholder-driven sustainable rate of growth methodology for the total cost of care and advise on related processes and timelines.

Recommended actions: by January 31, 2014, a sustainable rate of growth workgroup is appointed and its charter is endorsed.

- OHA and OID establish a sustainable rate of growth workgroup to advise a methodology development process.
- The workgroup members are appointed by and serve at the pleasure of the Commissioner of OID and Director of OHA.
- OHA reports quarterly to OHPB regarding progress toward developing a sustainable rate of growth methodology.
- The workgroup consults with stakeholders regarding the methodology and related components of this strategy. Stakeholders include but are not limited to the Oregon Health Leadership Council, the Oregon Student Public Interest Research Group and the Oregon Business Association, PEBB and OEBB

Recommended actions: by December 31, 2014, a sustainable rate of growth methodology is endorsed, measurement begins and potential accountability mechanisms are recommended.

- Sustainable rate of growth measurement includes but is not limited to measurements of health entities and health plan premiums year over year.
- OHA and OID ensure financial modeling is conducted, and that it shows the potential effect of a sustainable rate of growth benchmark on different market segments, the delivery system and overall financial implications.
- Because there is shared responsibility for the total cost of care, OHA and OID explore the benefit of and make recommendations to the Governor's office and 2015 Legislature about potential mechanisms to hold health plans and health entities accountable for cost increases beyond the sustainable rate of growth benchmark.

Appendix D: Sustainable Healthcare Expenditures Workgroup Committee Members

Members

Denise Honzel, Chair
Oregon Business Council

William Ely
Kaiser Permanente

Jesse Ellis O'Brien
OSPIRG

Kraig Anderson
Moda Health

James Gajewski, M.D.
Oregon Medical Association

William Olson
Providence Health & Services

Dean Andretta
WVP Health Authority

Jon Hersen
Legacy Health

Greg Van Pelt
Oregon Health Leadership Council

Peter Davidson
Pacific Source Health Plans

Glenn Johnson
PeaceHealth

Kelvin Wursten
Cambia Health Solutions

OHA

Lori Coyner, Director of Health
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Jeff Winkley, Senior Financial
Policy Advisor, OHA

OID

Laura Cali, Commissioner, OID

Gayle Woods, OID

Consultant

John McConnell, Ph.D.

Oregon Health & Science University
Center for Health Systems
Effectiveness

6/18/2015

Incorporating the Sustainable Healthcare Expenditures Workgroup into the Coordinated Care Model Alignment Workgroup

Below are the recommendations from the Oregon Health Policy Board for the future of the SHEW:

- The current SHEW will be disbanded and new group will be formed for phase 2 of the SHEW
 - The newly formed group will include members from the previous SHEW workgroup, members from the CCMA workgroup, and additional external members to be selected by the Oregon Health Authority
- SHEW 2.0 will live under the CCMA workgroup umbrella as a specific, time-limited subcommittee
- Oregon Health Authority will work closely with Brian Devore, the OHPB liaison, to define the scope of the SHEW 2.0
- Scope of SHEW 2.0 is still being determined, but options may include –
 - Reviewing total spending, trends, growth rate, and payers to identify variations in health care expenditures that can be targeted for further analysis
 - Determining opportunities to pilot or apply the existing sustainable rate of growth methodology as additional data is incorporated or analyzed
 - Developing recommendations for potential accountability mechanisms and policies aimed at containing or lowering the cost of care

Detailed Outline of Model Contract for CCM Inclusion

June 15, 2015

- I. *Introduction to Model Contract:*
 - a. Description of purpose of model contract (to implement the CCM; note that this model contract has been developed for larger self-funded employers to use in a contract with a Third Party Administrator (TPA));
 - b. Areas included
 - c. Additional items that would need to be included by an Employer
 - i. ID cards
 - ii. Customer Service, including development of provider directory
 - iii. Claims Payment
 - iv. Confidentiality

- II. *Contract purpose:* This section will use contract language to lay out the overall strategies in the contract and the key goals that the employer is trying to adopt with implementation of the CCM.

- III. *Comprehensive Services:* This section of the contract will detail the services that the employer wishes to purchase, consistent with the CCM. It will include different optional language to include in the following areas (at a minimum):
 - a. Required benefits
 - b. Requirement to select a PCP
 - c. Benefit design incentives for accessing preventive care services
 - d. Benefit design incentives for healthy behaviors
 - e. Variable cost sharing for over-utilized services
 - f. Care Management as required service
 - g. Care integration, including integration of behavioral health and physical health care
 - h. Formulary development
 - i. Use of Telemedicine

- IV. *Network Management:* This section will detail the required network and how the Plan is expected to manage its network.
 - a. Development of adequate network
 - b. Monitoring provider performance to inform quality and plan design (e.g., tiered or high-performing network)
 - c. Requirement of increased use of PCPCHs
 - d. Requirement to share performance data with provider network

- V. *Evidence-Based Care*: This section of the contract will detail requirements for implementation of best practices and how provider performance of those activities will be monitored.
 - a. Administration of health risk assessments
 - b. Use of patient activation strategies
 - c. Inclusion of shared-decision making
 - d. Requirement of use of Team-Based Care approaches
 - e. Requirements to use clinical protocols

- VI. *Quality*: This section will detail the quality requirements for the Plan;
 - a. Requirement for QIP
 - b. Requirement for use of standardized Quality Measures
 - c. [note: new bill just passed that will need to incorporate eventually]

- VII. *Payment Strategies*: This section will provide requirements around value-based payment strategies to be used by Contractor, including options for use of:
 - a. Population-based payments
 - b. P4P
 - c. Episode-based payments
 - d. Strategies designed to reduce waste
 - e. Strategies designed to support primary care

- VIII. *Information Technology*: This section will focus on the IT requirements for both the Plan and their network providers
 - a. General IT requirements (claims; encounter data)
 - b. Use of electronic health records
 - c. Sharing of information through Health Information Exchange
 - d. Use of health informatics/analytics to inform plan management

- IX. *Transparency*: This section will focus on transparency of information related to quality and cost so that consumers may make an informed decision about where to access care.
 - a. Full disclosure of provider performance to allow comparison
 - b. Full disclosure of price per provider per service to allow comparison

- X. *Contractor Performance*: This section will detail how employer will monitor contractor performance through performance guarantees and financial incentives and disincentives.
 - a. Overall sustainable rate of growth
 - b. Performance guarantees re: TPA performance and portion of administrative fee at risk
 - c. Performance incentives
 - d. Performance disincentives

Difference between Framework for Procurement and Contracting and Model Contract Language

The Framework document describes options for key activities to be included as part of a model contract that seeks to embrace and implement the Coordinated Care Model (CCM). While in some places the Framework document provides optional requirements, the Model Contract will provide more detailed contract language for all items within the Framework and some additional items that are crucial to setting the direction of the Contract to include the CCM.

Below is an example of how a Framework element will become more detailed through model contract language.

Language from Framework Document:

- 1. Primary care clinician.** Plan Participant shall be required to identify a primary care clinician. The Administrator shall make sure each Plan Participant has an identified primary care clinician and the clinician establishes a relationship with every attributed Plan Participant if one does not already exist at the time of enrollment.

Model Contract Draft Language:

1. Primary care clinician

- a. All plan participants shall be required to identify a primary care clinician.
- b. Contractor shall develop a process through which plan participants select a primary care clinician.
 - i. The Contractor's provider directory shall include all available primary care clinicians within the Contractor's network. As detailed in Section XX, the provider directory shall include information to assist a plan participant in selecting the most appropriate primary care clinician for his or her needs.
 - ii. The Contractor shall provide the plan participant with information on how to select a primary care clinician upon enrollment, including but not limited to:
 1. How long a plan participant has to select a primary care clinician
 2. How the plan participant selects the primary care clinician
 3. How a primary care clinician will be assigned to plan participants that do not select a primary care clinician.
 4. Whether and how often a plan participant shall have the option to select a different primary care clinician.
 - iii. The Contractor shall also develop a requirement for primary care physicians to reach out to plan participants that have selected or been assigned to them specifically, to establish a relationship with each attributed plan participant. The requirement shall describe how the primary care clinician is.

Oregon Health Authority and Oregon Health Policy Board

Coordinated Care Model Alignment Efforts Among Carriers and Purchasers

Environmental Scan Report

Coordinated Care Model Alignment Workgroup
6/15/2015

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DRAFT

Executive Summary

The Oregon Health Policy Board has charged the Coordinated Care Model Alignment (CCMA) Workgroup with spreading the Coordinated Care Model (CCM) to the commercial market. The Workgroup is charged with developing a host of tools that will assist in the implementation of CCM principles across multiple market segments, including a toolkit for purchasers. In addition, the CCMA Workgroup is sponsoring the environmental scan effort described in this report.

The environmental scan aims to develop a more comprehensive picture of Oregon's health insurance market and existing programmatic and operational efforts to adopt the CCM. The scan aims to develop a more robust understanding of the challenges, needs, and the resources available to facilitate the spread of the CCM. The Oregon Health Authority, with support from Bailit Health Purchasing, interviewed carriers and purchasers throughout the state. Developing an understanding of the various market segments and their underlying concerns and motivations will aid the Oregon Health Authority in the creation of a messaging and communications framework that describes the model and the benefits to the consumer, carrier, and purchaser. Additionally, the information will help the CCMA workgroup define other tools that might be helpful to purchasers and carriers thinking about adoption of the CCM components and for consumers seeking to understand the model.

From the interviews, the CCMA workgroup learned the following:

- 1) continued education about the Coordinated Care Model is critical;
- 2) collaboration and continued engagement between carriers, purchasers, and the Oregon Health Authority is necessary;
- 3) multi-payer payment reform is critical to support innovations in the care delivery model; and
- 4) the Oregon Health Authority and the CCMA workgroup should provide resources and support to purchasers and carriers as they determine the degree to which their infrastructure can support adoption of the CCM.

Continued education about the CCM is critical. Though many carriers and purchasers are aware of the CCM, those not involved as Coordinated Care Organizations (CCOs) typically have limited knowledge about the benefits of the model and the applicability of the model to their particular population. Several entities expressed a difficulty in translating particular pieces of the CCM to the commercial market. For example, several carriers and purchasers are unsure about the applicability of social determinants of health to the commercial market population because this population is typically higher income, in comparison to the Medicaid population.

Going forward it will be imperative to compile and communicate the evidence supporting the value (return on investment) of the model and its individual components to carriers, purchasers, and employees. Each of these groups will play a unique role in supporting the spread of the CCM. It will also be helpful to build awareness about the CCM among brokers and consultants because they often assist purchasers in designing benefits and selecting plan offerings, and will be essential to communicating the value of the CCM to employers.

Collaboration and continued engagement between carriers, purchasers, and the Oregon Health Authority is necessary. Though several carriers and purchasers have started to align with the CCM, there are limited opportunities to share lessons learned and successes implementing specific pieces of the model. As the CCM

spreads, the state, carriers and purchasers should collaborate to address challenges and barriers to the model's adoption. Now, carriers and purchasers are operating in silos attempting to understand and translate the model to their commercial environment and purchasing needs.

Several carriers and purchasers have started to adapt pieces of the CCM to the commercial market (e.g., behavioral health integration), and it would be helpful to share findings broadly across carriers and purchasers. The Oregon Health Authority has started to convene various organizations working on advancing the CCM. For example, in Fall 2013, almost all of Oregon's major public and private payers signed an agreement to support alternative payment strategies for Patient-Centered Primary Care Homes (PCPCHs) across the state. Additionally, the Transformation Center provides significant supports to CCOs through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. Four learning collaboratives are underway and focus on incentive pool metrics, provider approaches to complex care, and engaging CCOs' community advisory councils. Though this work has largely centered on CCOs, the state may have a role in convening future groups to foster learning and engagement across commercial entities working towards the same goal – implementation of the CCM.

Multi-payer payment reform is critical to support innovations in the care delivery model. Consistent with Oregon's CCM, there is a growing movement nationwide towards outcomes-based payment and away from a volume-based fee-for-service system. Payment for care should be based on quality and health outcomes rather than on volume of services provided. Carriers and purchasers agreed with the Oregon Health Authority view that to support better care and decreased cost growth, private- and public-sector payers should adopt alternative payment methodologies such as population-based payment (global payment), episode-based payment, and incentives for performance and quality outcomes. To slow the growth in overall health care system costs, it will be critical for commercial health insurance carriers to adopt payment innovations that shift provider and consumer behavior. However, carriers note that they do not always have enough market share on their own to implement these reforms.

Provide resources and support to purchasers as they determine the degree to which their infrastructure can support adoption of the CCM. Due to a lack of or limited infrastructure, several purchasers mentioned that state assistance is crucial to engender support of specific pieces of the CCM (e.g., alternative payment methodologies, behavioral health integration). Adoption of these particular components will likely occur more slowly without state support. The state should continue to develop resources and tools to assist purchasers in adopting the CCM and to improve overall understanding of the individual components of the model, such as toolkit for purchasers that the CCMA has begun to develop.

Background

What is the Coordinated Care Model?

Oregon’s CCM consists of six principles (see figure 1) that improve the quality and value of health care for individuals. Though the key elements can be adopted separately, they are most effective in achieving better health, better care and lower costs when used together. The six principles, as explained below, have been adopted by CCOs serving the Medicaid population.

- Using best practices to manage and coordinate care: The model is built on the use of evidence-based best practices to manage and coordinate care (e.g., value-based benefit design, patient-centered primary care homes). These best practices produce better care, improved outcomes (including a positive patient experience) and lower costs.
- Shared responsibility for health: When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and consumers can share responsibility and decision-making for care, while coming to joint agreements on how the individual wants to improve or maintain positive health behaviors.
- Transparency in price and quality: Cost and quality data that is readily available, reliable and clear helps patients understand their health plan and provider choices and it helps purchasers make decisions about choosing health plans. With access to data, patients can share responsibility in their health care decisions. Increased transparency on price and quality can also lead to increased accountability.
- Measure performance: Performance measurement that is consistent across health systems improves opportunities, performance, and accountability, while easing providers’ reporting burden. It may also help improve the quality of care in the health system as a whole.
- Pay for outcomes and health: Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. Innovative payment methods such as population and episode-based payments, and offering incentives for quality outcomes instead of volume-based fees support better care and lower costs.
- Sustainable rate of growth: Bending the cost curve is a vital component of the coordinated care model – and one that strengthens all other principles. Preventing a cost shift to employers, individuals, and families, and reducing inappropriate use and costs through a fixed-rate-of-growth approach is the foundation to health care transformation.



Figure 1

Spreading the Coordinated Care Model

Over time, the state hopes to incorporate the CCM principles used by the CCOs into all lines of business in the commercial market, including the Public Employees’ Benefit Board (PEBB), the Oregon Educators’ Benefit Board (OEBB), Cover Oregon, and the broader market. Adoption of the model principles across the commercial market will ensure that all Oregonians have access to coordinated and patient-centered care, lower out of pocket costs, and improved health outcomes.

To date, sixteen CCOs are up and operating, serving over 90% of Oregon Health Plan members. Recent data as of January 2015 show that of the approximate 71,450 duals in Oregon, 58% are enrolled in CCOs¹ by choice (not mandated to enroll) and receiving care based on the Coordinated Care Model. Many of the CCOs have affiliated Medicare Advantage plans, which has aided in duals engagement. Performance indicators show that CCOs have achieved the following preliminary outcomes: increase in primary care use and spending; decrease in inpatient stays due to chronic illness; and decrease in emergency department utilization and costs.²

The state is making large investments into the health care system and care delivery through the implementation of the CCOs. To ensure the CCM is sustainable, it must be ingrained into how care is delivered across Oregon. The Oregon Health Authority purchases significant commercial coverage for approximately 275,164 PEBB and OEBC subscribers (includes dependents). Employers purchase coverage for almost 2 million individuals.³ Through continued spread of the CCM to PEBB, OEBC, and the private market, including individual, small and large group insurance options, a larger portion of Oregonians will benefit from improved health outcomes and reduced costs.

Given early results showing improved outcomes through implementation of the CCOs, the state currently is working to spread the CCM to other state purchasers, including PEBB and OEBC. In 2015 contracts with eight health plans, PEBB required the plans to include CCM elements in their health benefit offerings. The forthcoming 2016 OEBC Request for Proposals aims to: 1) expand the CCM based health plan offerings and availability in Oregon counties; and 2) contract with health plan partners committed to transforming Oregon's healthcare system to achieve the Triple Aim for OEBC members and Oregonians. If the model does not spread to remaining portion of the commercial market, cost reductions in Medicaid could lead to cost increases for private payers, including insurers and self-insured employers, eventually shifting costs to the individual. It is critical that Oregon begin to bend the cost curve to ensure long-term cost savings and predictability for health insurers, employers, and individuals.

Understanding the Current Landscape

The degree and pace of CCM adoption will be impacted by differences between insured populations and unique market characteristics. Due to these variances, some market segments might have increased interest in specific pieces of the model or may select to phase-in certain elements of the model over time. To understand the opportunities for alignment across market segments, Appendix A provides a comparison of covered populations and plan design across different markets in Oregon. The findings from the environmental scan and Appendix A will help enhance our understanding of potential points of convergence across Oregon's market segments.

¹ Oregon Health Plan, OHP Data and Reports. "Enrollment report: January 2015 Medicare-Medicaid Enrollment." January 15, 2015. Available at: <http://www.oregon.gov/oha/healthplan/pages/reports.aspx>.

² Oregon Health Authority, Office of Health Analytics, "Oregon's Health System Transformation 2014 Mid-Year Report," January 2015. Available at: <http://www.oregon.gov/oha/metrics/Pages/index.aspx>

³ Oregon Health and Science University, Oregon Health Authority "Impacts of the Affordable Care Act on Health Insurance Coverage in Oregon: County Results/Statewide Update"; February 2015. Available at: <http://www.oregon.gov/oha/analytics/Documents/Health%20Insurance%20Coverage%20in%20Oregon%20County%20Results.pdf>.

To begin to understand the current health insurance market landscape in Oregon, the Office of Health Policy and Research (OHPR) and Bailit Health Purchasing conducted interviews with eleven commercial carriers⁴ and seven large employers⁵ to understand their interest and readiness to adopt the Coordinated Care Model. Twelve carriers and eleven purchasers received an invitation for an interview. Carriers selected for an interview participated in three or more market segments (e.g., small group, large group, Medicaid) and had a significant share of covered lives in Oregon. Interviewed carriers represent all of the largest insurers in the state. Purchasers selected for an interview were identified through a series of discussions with the Oregon Insurance Division and Coordinated Care Model Alignment Workgroup members. Interviewed purchasers only included large group employers and did not include small group employers, making the report's findings less representative of all Oregon purchasers.

The State aimed to obtain the following information from carriers and purchasers:

- Interest and readiness to adopt elements of the Coordinated Care Model;
- Programmatic and operational efforts supporting the Coordinated Care Model;
- Provider (hospital and physician) interest and readiness (carriers only);
- Challenges/barriers to Coordinated Care Model spread;
- Needs of the market segment affecting the ability to spread the model; and
- Available resources to facilitate the adoption of the model.

Interviewers used standardized questionnaires for each group. Appendices B and C contain the interview questionnaires used for health insurance carriers and purchasers, respectively.

⁴ Interviewed insurers included Kaiser Permanente, Lifewise, Moda, PacificSource, Providence, Regence Blue Cross Blue Shield, Trillium, Aetna, Cigna, Health Net Health Plan, and UnitedHealthCare.

⁵ Interviewed employers included Springfield School District, Trimet, Pape Group, Jeld-Wen, Peace Health, OHSU, and Multnomah County.

Themes from Carrier Interviews

There is significant interest in aligning with the Coordinated Care Model.

Most of the carriers were generally aware of the CCM and expressed interest in aligning with the model and its principles in the years to come. Many carriers have already adopted certain elements of the CCM (e.g., medical home, care coordination), and are tailoring other model components to the intricacies of the commercial landscape in Oregon. For example, a carrier has a commercial medical home network that builds specific commercial requirements on top of the Patient Centered Primary Care Home (PCPCH) program standards. As noted below, carriers are just beginning to implement payment reform in the commercial market and are interested in ensuring that there is enough alignment across the market to ensure reform works based on their own market size. Several carriers felt that only certain elements of the model are applicable to the commercial market, while others are most pertinent to the Medicaid market, but all acknowledged that they need to change how care is delivered to reduce overall health care cost growth. Carriers involved with the CCOs are generally further along in translating the model to the commercial side.

Quote: "The instinct that we should want to bring more of the CCM principles to commercial carriers makes total sense, but the commercial marketplace has some uniqueness not present in Medicaid and there is variability in demands among self-funded customers. A lot of evolution would need to happen within individual components of the CCM before we can apply it to value-based purchasing approaches on the commercial side."

There is varying progress in payment reform outside of Medicaid.

There seems to be considerable interest in paying for value and moving away from FFS and a number of carriers are piloting specific alternative payment methodologies (APM) (e.g., pay for performance, PCPCH supplemental payment, shared savings and/or risk, capitation, bundled payment) based on services or networks. Many carriers are trying to determine the appropriate payment mechanism for their line of business and population demographics, especially for those with a smaller number of covered lives. According to carriers, many providers seem to have limited interest and capacity to support payment reform. Though payment models are supposed to create shared responsibility among providers and reward improved outcomes, many carriers do not feel that there has been decisive evidence in support of any particular payment model. Those that are further along in payment reform use a variety of APMs and apply them differently to providers and networks.

Quote: "Trying to move providers from volume towards working within a budget. On the commercial side it's harder to get traction on alternative payments and attribute members to providers, so the shift is going to be slower."

Limited use of tiered or high-performing networks.

Though many carriers are capable of providing tiered network products, there is not a significant demand for these types of products, so they are not widely offered. Those that offer products with tiered networks typically tier according to cost and quality. Some of the tiered networks are specific to specialists or other narrow networks of providers. Many health plans have introduced high performing networks to encourage the use of providers that are deemed as high performing on efficiency and quality measures. However, in Oregon, few carriers offer high performing provider networks currently because most purchasers request broad networks, but there is plan interest in developing these further in the Northwest market.

Quote: "Though these products are available, there has been limited use of these networks. Many employers want broad networks and brokers have not mentioned that there is interest in these options."

Willingness to have common health outcomes and quality measure set.

The majority of domestic carriers are in support of a common, standardized performance measure set to minimize the burden and costs on providers, but many stated that the measures should be aligned with other national certification reporting requirements (e.g., NCQA and HEDIS). National carriers stated that they face some difficulty in adopting and committing to a common performance measure set because there is high variance across the states they serve. A few carriers mentioned that the measures recommended by the Health Plan Quality Measure Workgroup require additional refinement to fit the needs of the commercial market.

Quote: "The conversation about a common measure set is happening in many venues. We are interested in looking at this but we need to make sure that the common set of measure set addresses other requirements (e.g., NCQA, HEDIS) and that they are the right measures for a commercial population."

Limited focus on whole-person health, behavioral health integration or social determinants of health outside of Medicaid population.

A number of carriers are beginning to integrate behavioral health into the primary care setting, yet few have made significant progress in care integration. Though carriers recognize the importance of behavioral health and physical health integration, several are still determining how they can support integration efforts and there is some exploration in this area through grant and community benefit funding to providers and community-based organizations. For example, one carrier has collaborated with a local community health center to develop a complex care center that addresses barriers to wellness, including behavioral health issues, through targeted patient identification, specialized, team-based primary care.

Quote: "Behavioral health has to be an integral part of care delivery but we have not found the right solution to ensure that care is actually integrated. This will be a focus moving forward."

Few carriers have started to think about social determinants of health for the commercial population and a number of them stated that they do not feel social service supports are as crucial for this group. When these supports are necessary, they are addressed at the individual level through case management services. Those that have started thinking about social determinants of health are trying to understand the demographics of their population, including health risk factors, and determining how to scale targeted services to populations in commercial products. Carriers that are involved with the CCOs are further along in thinking about and incorporating social determinants of health into the benefits and services offered. For example, CCO-involved plans that provide coverage in the commercial market have a delivery system that offers established care integration and standing relationships with social agencies giving them a relative advantage in addressing social needs.

Quote: "One of the challenges is how to scale these social supports services to less risky populations when employers are focused on lower premiums."

Majority of carriers share performance reports with providers to assist them in managing their patient panels.

Most carriers are focused on sharing a variety of performance and member care reports with providers, so that they can improve quality of care, track patient health needs, and manage their panels. A number of carriers engage provider organizations in continued discussions to target improvements in areas identified as low performing within reports. Several carriers mentioned that they wanted to develop more robust reporting for providers. Carriers that share performance reports with purchasers focus on quality outcomes (e.g., HEDIS) and costs of population experience.

Quote: “We provide a suite of reports to providers (and employers) that show how a provider is doing compared to past performance and network averages of cost and quality and, for selected providers, we provide care gap reports to ensure members are receiving routine preventive services.”

Significant carrier interest in adding or strengthening telehealth capabilities.

Many carriers have telehealth programs in place and are thinking of using these programs to target services to population needs (e.g., geographic need, specialty care, urgent, primary care). Several carriers contract with national vendors to offer telehealth services to consumers. Others who do not offer telehealth services are funding provider grants to develop such capabilities and are continuing to explore the area to determine an appropriate approach.

Quote: “Telehealth is starting to expand how we deliver care, especially in remote areas. There is a lot of interest in further exploring this area to deliver these types of services effectively.”

Themes from Purchaser Interviews

High use of brokers and consultants for plan selection and benefit design.

All of the purchasers interviewed rely on brokers and/or consultants to design their benefit packages. Some employers, particularly those with union employees, have benefit councils or committees that weigh in on benefit and plan selections. Involvement with particular brokers/consultants can affect what an employer thinks they can do on their own vs. with a carrier. The more engaged the broker or consultant is in delivery system reform conversations, the more likely the employer is engaged in addressing delivery system reform and feels empowered to try to move delivery system forward. Those employers who rely on brokers that are not as engaged in delivery system reform are more likely to purchase what is offered by the carrier with little understanding of where they may have the opportunity to push for change.

Most of the employers in this sample are self-insured or thinking of moving towards being self-insured.

Most purchasers we interviewed have recently moved to being self-insured believe they can more easily achieve cost savings. A couple of purchasers still offer a mixture of fully insured and self-insured products, but they are also considering cost saving options. A couple of purchasers mentioned that they are starting to think about making changes to their benefit offerings due to the upcoming excise tax under the Affordable Care Act.

Employers provide minimal direction or do not require carriers to incorporate CCM components into plan design.

Most employers are hands-off with plan design and inclusion of innovative payment and care delivery options into plan offerings. Many are reliant on the carrier plan offerings and do not push carriers to design offerings that are tailored to their employees’ unique needs. Employers with limited buying power – those with fewer covered lives – feel that they don’t have the leverage to influence carriers to implement the CCM. One employer described that it is seeking to combine purchasing power with another employer to better be able to direct plan design.

Quote: "Many of the delivery system and payment innovations are outside of our negotiation with carriers and those generally happen in contracts between the carrier and provider."

Efforts to align with the Coordinated Care Model are limited to certain employers.

Employers that are government entities or are health care based are more focused on implementing a CCM-like model than others. Only one employer outside of these two areas has made significant efforts to incorporate model components into its plan design and develop solutions with outside contractors. Employers subject to collective bargaining may have a harder time incorporating CCM components, but many are interested in educating union representatives about the model to ensure adoption.

Quote: "We are looking to use our TPA's product that has coordinated care facets and will model a plan option around the CCM."

A number of purchasers have employees across several states limiting their ability to implement components of the CCM due to coordination challenges. Those with larger pockets of Oregon based covered lives are willing to push carriers towards adoption of certain model components.

Many recognize the need to educate themselves and their workforce about health coverage options and the CCM.

Overall, it was apparent that there is limited knowledge and awareness about the CCM among employers and education/outreach will be critical to help employers and employees understand the benefits of the model. Most employers stated that employee education would be necessary to help individuals understand their options, health benefits and the CCM. Some stated that they are looking to the state to develop educational materials for employees and employers around the CCM.

Quote: "It will be important to educate employees and the union about the CCM, so that we can start moving in that direction. We will need resources and tools that the state has developed about the model."

Employers reported that incentives are helpful to motivate and engage employees in their health.

A majority of employers offer incentives (monetary and non-monetary) to employees for healthy behaviors, use of preventive services, and/or use of evidence-based services. Many employers engage employees in wellness challenges at the workplace or offer incentives to participate in wellness activities offered through the carrier(s) or separate wellness vendors.

Quote: "Though we don't offer direct incentives, we offer employees various supports and promotions throughout the year in partnership with local community organizations, the plan, and workplace wellness programs."

Some employees have identified access to providers as an important criterion for plan selection.

A few service industry employers mentioned that there is significant interest among their employee base in maintaining a broad provider network. Employees might consider a plan option based on the CCM to be unfavorable if it is perceived as having a limited or restricted network.

Quote: "There is an interest among employees in maintaining broad access to providers, including alternative medicine such as naturopathy and massage therapy."

A handful of purchasers are starting to think about the applicability of social determinants of health to their employee base.

Though most purchasers are not focusing on social determinants of health, a few are discussing how to best address social needs through their benefit offerings given the additional health care costs associated with

individuals requiring social supports. One purchaser has already implemented a health advocate program that helps employees navigate the health care system and connect them with community resources to overcome socioeconomic needs.

Quote: “We have talked about social determinants of health a lot but we have been unable to come to a consensus about how we might be able to address this issue. Everyone understands that there might be value to an individual but there are associated costs and it is difficult to determine if the employer (and the benefit plan) has the licensure to address social needs. Additionally, there are issues with the administration of benefits related to social determinants of health that would require resource tradeoffs for the employer to be able to incorporate such supports into benefit offerings. We simply do not have the infrastructure to support this effort, and it would be helpful if the state created programming (using economies of scale) to facilitate employer participation.”

DRAFT

Appendix A

Comparison of Oregon's Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design				
	Oregon Health Plan ⁶	Public Employees' Benefit Board (PEBB) ⁷	Oregon Educators' Benefit Board (OEBB) ⁸	Commercial ⁹
Eligible populations	<ul style="list-style-type: none"> • Non-pregnant adults ages 19-64 with income up to 138% FPL • Pregnant women ages 21 and older with income up to 185% FPL • Kids and teens (ages 0-18) with income up to 300% FPL (children's Medicaid up to 185% FPL) • Blind and disabled up to 75% FPL and those meeting the long-term care criteria up to 225% FPL 	<ul style="list-style-type: none"> • State agency employees • University employees • Lottery and semi-independent state agencies 	<ul style="list-style-type: none"> • Employees of school districts, educational service districts, community colleges and public charter schools • Employees of two counties and two special districts • Eligible to join – nine school districts, one community college, and 1,218 local governments and special districts 	<ul style="list-style-type: none"> • Small group: employees of small employers (starting in 2016 defined as 1-100 employees) • Large group: employees of large employers (starting in 2016 defined as 101 or more employees) • Individual: medical policies for Oregon subscribers and eligible dependents • Other: associations and trusts
Covered lives	As of April 2015, there are 1,081,835 members	As of March 2015, there are 132,964 subscribers and dependents	As of March 2015, there are 142,200 subscribers and dependents	As of 2014 Q2: <ul style="list-style-type: none"> • Small group – 161,948 individuals • Large group – 567,280 individuals self-insured – 777,094 individuals • Individual/direct purchase – 202,757 individuals • Associations and trusts – 108,872 individuals

⁶ Sources: 2014 Medicaid BRFSS Survey and Oregon Health Plan data and reports

⁷ Sources: 2013 BRFSS of State Employees and PEBB website and member handbook

⁸ Sources: 2013 BRFSS of School Employees and OEBB member handbook and website

⁹ Sources: 2011 and 2013 Oregon Behavioral Risk Factor Surveillance System (BRFSS), OHSU Impacts of the Affordable Care Act on Health Insurance Coverage in Oregon: County Results/Statewide Update and Oregon Insurance Division website

Comparison of Oregon's Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design				
	Oregon Health Plan ⁶	Public Employees' Benefit Board (PEBB) ⁷	Oregon Educators' Benefit Board (OEBB) ⁸	Commercial ⁹
Age, gender, ethnicity	<ul style="list-style-type: none"> Age: <ul style="list-style-type: none"> – 43% are children – 40% are adults – 13% are aged Gender: 59.8% are female Race/ethnicity: <ul style="list-style-type: none"> – 78.5% are white – 15.2% are Hispanic – 3.3% are American Indian/Alaska Native – 1.4% are African American – 1.8% are Asian (includes Pacific Islander) 	<ul style="list-style-type: none"> Mean age is 48.6 Gender: 57.5% are female Race/ethnicity: 4% are Latina/o 	<ul style="list-style-type: none"> Mean age is 47.5 Gender: 74.8% are female Race/ethnicity: 4.6% are Latina/o 	<ul style="list-style-type: none"> Age: <ul style="list-style-type: none"> – 12.7% are between 18-34 – 28.1% are between 35-54 – 25.4% are between 55-64 – 33.7% are 65 and older Gender: 59% are female Race/ethnicity: <ul style="list-style-type: none"> – 78.5% are white – 11.7% are Latina/o – 3.7% are Asian – 1.8% are African American – 1.4% are American Indian/Alaska Native
Geographic coverage	16 CCOs provide coverage in all 36 Oregon counties	All 36 Oregon counties have two or more medical plans available	Coverage in every Oregon county	Coverage limited to contracted plan service areas
Prevalence of chronic conditions/disabilities	<ul style="list-style-type: none"> 64.7% of Medicaid BRFSS (MBRFSS) respondents have a chronic disease 36.8% of MBRFSS respondents are depressed 56% of MBRFSS respondents had limited activity due to poor health¹⁰ 	<ul style="list-style-type: none"> 15.5% of PEBB BRFSS respondents are limited in activities due to physical, mental, or emotional problems 46.2% of PEBB BRFSS respondents have a chronic disease¹¹ 	<ul style="list-style-type: none"> 14.7% of OEBB BRFSS respondents are limited in activities due to physical, mental or emotional problems 47.4% of OEBB BRFSS respondents have a chronic disease¹² 	<ul style="list-style-type: none"> 21.3% of BRFSS respondents stated that they are limited in activities because of physical, mental, or emotional problems 61.5% of BRFSS respondents are at risk for chronic disease¹³
Socio-economic factors	<ul style="list-style-type: none"> Household income – see eligibility notes above Educational attainment is low (31.7% have some college and 55.6% completed grade 12 or less) 48.6% of MBRFSS respondents are food 	<ul style="list-style-type: none"> Household income: <ul style="list-style-type: none"> – 20.3% of PEBB BRFSS respondents make \$25,000 to less than \$50,000 – 77.9% of PEBB BRFSS respondents make \$50,000 or more 	<ul style="list-style-type: none"> Household income: <ul style="list-style-type: none"> – 24.1 % of OEBB BRFSS respondents make \$25,000 to less than \$50,000 – 69.1% of OEBB BRFSS respondents make \$50,000 or more 	<ul style="list-style-type: none"> Household income: <ul style="list-style-type: none"> – 59.8% of all BRFSS respondents (including those who might have coverage listed to left) make less than \$50,000 – 40.3% of all BRFSS respondents make \$50,000 or more

¹⁰ Limited activity on 1+ days of last 30

¹¹ Includes asthma, arthritis, diabetes, heart attack, heart diseases, stroke, cancer, or depression.

¹² Ibid.

¹³ Based on BMI being greater than 25.0

Comparison of Oregon's Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design				
	Oregon Health Plan ⁶	Public Employees' Benefit Board (PEBB) ⁷	Oregon Educators' Benefit Board (OEBB) ⁸	Commercial ⁹
	<p>insecure</p> <ul style="list-style-type: none"> 22.3% of MBRFSS respondents are more likely to be hungry 	<ul style="list-style-type: none"> Educational attainment is high (71% graduated college and 19% have some college) 	<ul style="list-style-type: none"> Educational attainment is high (71% graduated college and 17% have some college) 	<ul style="list-style-type: none"> Educational attainment is moderate (26.5% are college graduates and 35.4% attended some college) 19.8% of all BRFSS respondents live in food insecure households
Out of pocket expenses	<p>Generally there is no cost sharing, but adults receiving OHP Plus or OHP Limited Drug benefits have a \$3 co-payment for certain types of outpatient services and a \$1 or \$3 copayment for certain prescription drugs (unless they are exempt)</p>	<ul style="list-style-type: none"> Kaiser OOP max – \$600/person, up to \$1200/family All other plans OOP max – \$1500/person, up to \$4500/family 	<ul style="list-style-type: none"> Kaiser OOP max – ranges from \$1500- \$5000/person, \$3000- \$10000/family Moda OOP max – ranges from \$2400-\$5000, \$7200- \$12,700/family 	<ul style="list-style-type: none"> OOP costs for Individual and small group plans on the exchange will vary depending on monthly premium and metal level OOP max for non-grandfathered small and large group plans is \$6,600/person up to \$13,200/family (includes self-funded plans)
Benefit design	<p>Robust medical, mental health and chemical dependency services and limited dental</p>	<p>Robust medical (includes vision), dental, and optional benefits (e.g., life insurance, short term disability insurance)</p>	<p>Robust medical (includes vision), dental, and optional benefits (e.g., life insurance, short term disability insurance)</p>	<ul style="list-style-type: none"> Individual and small group benefits are based on the Essential Health Benefits benchmark plan selected by the state <ul style="list-style-type: none"> There are various limitations on scope, amount and duration of services Dental and vision coverage must be purchased separately Large group benefit offerings are likely more limited, especially in scope, amount and duration of services
Participating carriers	<ul style="list-style-type: none"> AllCare Health Plan Cascade Health Alliance Columbia Pacific CCO (plan partner-Care Oregon) Eastern Oregon CCO (plan partner- 	<ul style="list-style-type: none"> Kaiser Foundation Health Plan of Northwest covers 22,474 subscribers and dependents AllCare Health Plan covers 1,575 subscribers and dependents 	<ul style="list-style-type: none"> Moda Health Plan covers 104,695 subscribers and dependents Kaiser Permanente of the Northwest covers 24,700 	<p>Individual (I), small group (SG), and large group (LG):</p> <ul style="list-style-type: none"> Aetna (LG) Atrio (I, SG) Bridgespan Health Company (I)

Comparison of Oregon’s Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design

	Oregon Health Plan ⁶	Public Employees’ Benefit Board (PEBB) ⁷	Oregon Educators’ Benefit Board (OEBB) ⁸	Commercial ⁹
	<p>Moda)</p> <ul style="list-style-type: none"> • Family Care (plan partner- FamilyCare) • Health Share of Oregon (plan partners- CareOregon, Kaiser, Providence) • Intercommunity Health Network CCO (plan partner- Samaritan) • Jackson Care Connect (plan partner- CareOregon) • Pacific Source Community Solutions CCO Central Oregon (plan partner- PacificSource) • Pacific Source Community Solutions CCO Columbia Gorge (plan partner- PacificSource) • PrimaryHealth of Josephine County (plan partner- CareOregon) • Trillium Community Health Plan • Umpqua Health Alliance (plan partner- Atrio) • Western Oregon Advanced Health CCO • Willamette Valley Community Health (plan partner-Atrio) • Yamhill CCO (plan partner-CareOregon) <p>Enrollment information is available at http://www.oregon.gov/oha/healthplan/pages/reports.aspx</p>	<ul style="list-style-type: none"> • Moda Health Plan covers 2,947 subscribers and dependents • Providence Health Plan covers 105,883 subscribers and dependents • Trillium Community Health Plan covers 90 subscribers and dependents 	<p>subscribers and dependents</p>	<ul style="list-style-type: none"> • Cigna (LG) • Connecticut General Life Insurance Company (LG) • Health Net Health Plan of Oregon (I, SG, LG off exchange) • Health Republic Insurance (Freelancers CO-OP) (I, SG) • Kaiser (I, SG, LG) • Lifewise Health Plan of Oregon (I, SG, LG) • Moda (I, SG, LG) • Oregon’s health CO-OP (I, SG, LG on exchange only) • Pacific Source (I, SG, LG) • Providence (I, SG, LG) • Regence Blue Cross Blue Shield (I, SG, LG off exchange only) • Samaritan (SG off exchange only) • Time Insurance Company (I off exchange) • Trillium (I, SG) • United Healthcare Insurance Company (SG, LG off exchange) • UnitedHealthcare of Oregon (SG, LG off exchange)
Regulatory entities	<ul style="list-style-type: none"> • Social Security Act Title 19 and Title 21 • July 2012 1115 Waiver Demonstration 	<ul style="list-style-type: none"> • Oregon legislature (ORS 243.061 to 243.145) • PEBB Board • Collective bargaining 	<ul style="list-style-type: none"> • Oregon legislature (ORS 243.860 to 243.886) • OEBB Board • Collective bargaining 	<ul style="list-style-type: none"> • Collective bargaining • Essential Health Benefits for individual and small group 45 CFR Parts 147, 155, and 156 • Oregon Insurance Division (does not regulate self-insured market segment)

Appendix B

Coordinated Care Model – Carrier Interview Questions

Overview

The vision of Governor Kitzhaber and the Oregon Health Policy Board is that broader adoption of Coordinated Care Model (CCM) principles will unite Oregon’s markets in the drive towards achieving the triple aim of better health, better health care, and lower costs. To begin to understand the current health insurance market landscape, the Office of Health Policy and Research (OHPR) will conduct interviews with carriers to understand commitment to the principles of the CCM and programmatic and operational efforts to adopt it, including challenges, needs, and the resources available to facilitate the spread of the CCM.

Through these questions, the State will aim to obtain information from carriers in the following areas:

- Carrier programs/operations supporting the CCM;
- Provider (hospital and physician) interest and readiness;
- Challenges/barriers for further spread;
- Needs of the market segment constraining the ability to spread the model; and
- Resources available to facilitate the adoption of the model.

General Plan Information

We would like to understand the market segments served by your plan and how many lives you serve in each segment.

Market	Covered Lives	Sample Employers
Individual		
Small Group (fully insured)		
Large Group (fully insured)		
Self-Insured		
Medicaid		
Medicare Advantage		

Coordinated Care Model (CCM)

As you know, Oregon has developed a Coordinated Care Model and implemented it for the Medicaid program via contracts with Coordinated Care Organizations. [Review CCM Model with interviewee]

1. Are you familiar with the Coordinated Care Model? If yes, what aspects of the model are of interest to you? Are there aspects of the model you are not inclined to implement within your offerings?
2. [If no, provide an explanation.] Do you believe, based on what I have described, your organization is utilizing similar principles in the coverage you are providing. If not, where are the points of divergence?
3. If you offer a Medicare Advantage plan are there any specific barriers to implementing the CCM based on Medicare rules?

Strategies to Change Patient Behavior

We are interested in activities you have undertaken that may influence a consumer's behavior in terms of choosing providers and engaging in care.

1. Please describe your efforts to implement patient (member) behavior change strategies, including any notable employee or provider reaction to such efforts:
 - a. Transparency of provider performance on:
 - i. Quality
 - ii. Cost or efficiency, including relative to a member's deductible and coinsurance
 - b. Tiered networks
 - i. Please describe the patterns of service delivery in your market and whether there are any providers that are seen as "must haves" in any provider network.
 - ii. How do you tier the network? Is it based on quality, cost or a combination?
 - c. High Performing (select) networks
 - d. Value-based benefit design
 - i. Incentives for use of preventive services
 - ii. Incentives for healthy behaviors
 - iii. Incentives for use of evidence-based services
 - e. Wellness programs and/or tools
 - f. Shared decision making tools
 - g. Patient activation or engagement in management of health conditions
2. How do your products address social determinants of health, if at all? Do you offer any assistance in addressing social needs that impact health?

Payment and Delivery Innovations

We are interested in understanding the activities you have undertaken to move from fee-for-service payment; support providers in transformation to new payment and delivery models, and the financial and non-financial incentives that you have used to bolster provider accountability.

3. Has your organization participated in any reforms to the fee-for-service payment system as described below?
 - a. Implementation of non-payment and/or reporting of adverse events?
 - b. Use of supplemental payments for PCPCH (Medical Home) and/or clinical care management programs?
 - c. Institution of reference pricing for treatments and/or procedures?
4. Has your organization encouraged (through contractual requirements or through financial or non-financial incentives) and supported (with reports, payment, TA or other resources) the following activities among providers?
 - a. Care coordination and continuity of care for members, especially for individuals with complex needs
 - b. Patient-centered models of care
 - c. Integration of physical health, mental health, and addictions services
 - d. Programs for high-risk members (e.g., case management, disease management, pharmacy benefit management)

5. Please describe your organization's efforts in the area of Health Information Technology that have resulted in increased access and sharing among providers and care delivery improvements.
 - a. Adoption and meaningful use of EHRs and health information exchange
 - b. Telehealth programs
 - c. Provision of data, reports and/or analytics tools to contracted providers
 - d. Other efforts
6. Please describe any intent or actions to adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup. If no actions have been taken, are you open to using a common measure set in your performance-based contracts with providers?
7. Please describe your organization's past and current attempts at payment innovation and provider accountability (P4P, PCPCH supplemental payment, shared savings and/or risk, capitation, bundled payment), including the scale and impact of the efforts. What percentages of your covered lives or payments roughly fall under one or more of these models at present?
8. What, if anything, have you done in your contracts with providers to slow the effects of provider price growth on medical trend?

Appendix C

Coordinated Care Model – Large Employer Interview Questions

Overview

The vision of Governor Kitzhaber and the Oregon Health Policy Board is that broader adoption of Coordinated Care Model (CCM) principles will unite Oregon's markets in the drive towards achieving the triple aim of better health, better health care, and lower costs. To begin to understand the current health insurance market landscape, the Office of Health Policy and Research (OHPR) will conduct interviews with employers to understand their interest in incorporating the principles of the CCM into their health benefits purchasing practices, including the steps they have or will take. The interviews will also query employers about the challenges, needs, and the resources available to facilitate the spread of the CCM.

Through these questions, the State will aim to obtain information from employers in the following areas:

- Employer support for the CCM;
- Employer challenges/barriers to CCM spread;
- Perceived carrier interest and readiness;
- Resources available to employers to facilitate the adoption of the model.

General Purchasing Information

We would like to understand how many lives are covered through your purchasing and from which carriers you purchase health coverage.

1. Is your organization self-insured or fully insured?
2. Do you provide health coverage as part of a defined benefit package or a defined contribution (e.g., do employees have a set amount of funding to put towards health coverage and other benefits)?
3. How many plans do you offer to your employees, and from which carriers?
4. If you offer more than one plan design, what is the plan design the largest group of employees select?
[insert table with basic descriptive variables]
5. How many individuals do you purchase coverage for by carrier and plan type?
6. Do you receive outside assistance in devising your health benefits and wellness strategies? If so, who provides that support?
 - a. Broker
 - b. Health benefits consultant
 - c. Wellness consultant or vendor
 - d. Plan administrator/carrier
 - e. Employer coalition

Coordinated Care Model (CCM)

As you may know, Oregon has developed a Coordinated Care Model and implemented it for the Medicaid program via contracts with Coordinated Care Organizations. [Review CCM Model with interviewee]

4. Are you familiar with the Coordinated Care Model? If yes, what aspects of the model are of interest to you? Are there aspects of the model that you would not be inclined to request carriers to implement?
5. [If no, provide an explanation.] Do you believe, based on what I have described, your organization is utilizing similar principles to the CCM. If not completely, where are the points of divergence?

Strategies to Change Patient Behavior

We are interested in activities you have undertaken that may influence a consumer's behavior in terms of choosing providers and engaging in care.

9. Does your health benefits strategy include efforts to motivate patient (member) behavior change strategies, such as:
 - a. Transparency of provider performance on:
 - i. Quality
 - ii. Cost or efficiency, including relative to a member's deductible and coinsurance
 - b. Tiered networks
 - i. If you include tiered networks, are they tiered based on quality, cost or a combination?
 - c. High Performing (select) networks
 - i. Are there any "must have" providers that you feel you must have available to your employees?
 - d. Value-based benefit design
 - i. Incentives for use of preventive services
 - ii. Incentives for healthy behaviors
 - iii. Incentives for use of evidence-based services
 - e. Wellness programs and/or tools
 - i. HRA
 - ii. health coaching
 - iii. weight loss
 - iv. smoking cessation
 - v. exercise
 - vi. stress reduction
 - f. Shared clinical decision making tools
10. Does your health benefit strategy address social determinants of health? Do you offer any assistance in addressing social needs that impact health?

Payment and Delivery Innovations

We are interested in understanding whether you have directed your carrier(s) to take steps with its contracted providers to a) move away from fee-for-service payment; b) support providers in transformation to new payment and delivery models, and c) use the financial and non-financial incentives to bolster provider accountability.

1. Does your organization participate in an Employer Coalition focused on health purchasing?
2. Has your organization participated included any of the following within its carrier agreements?
 - a. Implementation of non-payment and/or reporting of adverse events?
 - b. Institution of reference pricing for treatments and/or procedures?
3. Do your agreements with carriers require any of the following activities?
 - a. Patient-centered models of care (e.g., PCPCH)

- b. Integration of physical health, mental health, and addictions service delivery
 - c. Programs for high-risk members (e.g., case management, disease management, pharmacy benefit management)
 - d. Care coordination for members, especially for individuals with complex needs
4. Do your agreements with carriers include any requirements regarding Health Information Technology that may increase access and sharing among providers and care delivery improvements?
- a. Adoption and meaningful use of EHRs and participation in a health information exchange
 - b. Telehealth programs
 - c. Provision of data, reports and/or analytics tools to contracted providers
 - d. Other efforts (please specify)
5. Please describe how your organization looks at the quality of care provided to your employees and their dependents at both the health plan level and at the provider level. Are there any incentives in your agreements based on the quality of care?
6. Are you familiar with the provider performance measures developed by the Health Plan Quality Measures Workgroup? Do you plan to require your carriers to implement them?
7. Do your agreements with carriers include any requirements regarding payment innovation and provider accountability, such as:
- a. P4P
 - b. PCPCH supplemental payment
 - c. care management supplemental payment (if distinct from PCPCH)
 - d. shared savings and/or risk
 - e. capitation
 - f. bundled payment

Do you have any sense of what percentage of your covered lives or payments roughly fall under one or more of these models at present?