

2014 Coordinated Care Model Alignment Workgroup

September 29, 2014
10:30 a.m. – 12:30 p.m.

Lincoln Building, Oak Room
421 SW Oak Street
Portland, Oregon 97204

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

Meeting #1			
#	Time	Item	Lead
1	10:30	Approval of meeting minutes, meeting objectives, and updates	Kelly Ballas
2	10:35	Feedback on timeline and work plan	Kelly Ballas
3	10:45	Starting the environmental scan <ul style="list-style-type: none">– Group homework request: <i>Understanding the Extent of Innovative Purchasing Strategies across the Oregon Health Insurance Market</i>– Carrier overlap among market segments– Approach for environmental scan– Feedback on environmental scan survey tool	Jeanene Smith
4	12:15	Meeting schedule	Veronica Guerra
5	12:20	Public comment	
6	12:30	Adjourn meeting	

Meeting materials:

- Workgroup roster, work plan, and timeline
- Group homework request: *Understanding the Extent of Innovative Purchasing Strategies across the Oregon Health Insurance Market*
- Enrollment in Oregon Health Insurance Market Segments
- Carrier overlap chart
- Coordinated Care Organization (CCO), Public Employees' Benefit Board (PEBB), and Oregon Educators Benefit Board (OEBB) Alignment with Coordinated Care Model Principles
- Environmental scan survey tool

Upcoming meetings:

- November 13, 2014 from 12:00 p.m. – 2:00 p.m. in Salem
- December 11, 2014 from 12:30 p.m. – 2:30 p.m. in Portland
- February 4, 2015 from 2:00 p.m. – 4 p.m. in Portland
- March 20, 2015 from 1:30 p.m. – 3:30 p.m. in Salem

**2014 Coordinated Care Model Alignment Workgroup
Meeting Summary**

August 13, 2014 from 2:00-4:00 pm

Committee Members in Attendance

Terry Coplin
Marc Gonzales
Denise Hall
Kathy Loretz
Diane Lovell
Jessie O'Brien

Robin Richardson
Gayle Woods for Laura Cali
Jennifer Lewis-Goff for Nora Leibowitz

Committee Members Not in Attendance

Dan Forbes

Staff

Kelly Ballas, OHA
Lisa Angus, OHA
Fritz Jenkins, OHA

Jeanene Smith, OHA
Veronica Guerra, OHA
Margie Fernando, OHA

Also in Attendance

Sean Kolmer, Governor Kitzhaber's Health Policy Advisor

1. Welcome and Introductions

Jeanene Smith welcomed everyone to the first meeting of the Coordinated Care Model Alignment Workgroup and members introduced themselves. Kelly Ballas expressed gratitude to the members for agreeing to participate on the committee.

He introduced Sean Kolmer, the Governor's Health Policy Advisor, who provided background on the Governor's vision for the health care system and the importance of the workgroup. He stressed the importance of alignment across the market to achieve delivery system reform and long-term investments in health improvement. Sean Kolmer thanked the members for agreeing to take on the task of formulating recommendations to spread the Coordinated Care Model.

2. Review of charter, timeline, and work plan

When reviewing the group membership, Kelly solicited additional recommendations from the current members for large and small business representatives. Additionally, Jeanene requested suggestions for self-insured business representatives. Members suggested Jordan Pape as a potential member for the group. They also suggested reaching out to Ryan Deckert from the Oregon Business Association (OBA) to provide recommendations from among the OBA membership.

Kelly reviewed the charter, the individual charges, the work plan and timeline for the group. The workgroup is expected to provide a final report to the Oregon Health Policy Board by June 2016. The charge given to this committee is to:

- Develop a timeline and work plan to spread the Coordinated Care Model;
- Conduct and publish an environmental scan assessing broad market needs regarding implementation and spread of coordinated care model principles;
- Develop common contract terms and “tool-kit” (e.g. Coordinated Care Model RFP template) for interested purchasers;
- Develop and adopt a process for organizational alignment and shared learning among purchasers to foster broad implementation of the Coordinated Care Model and aligned purchasing policies and standards;
- Support systems wide measure and metrics alignment;
- Collaborate with private purchasers to spread the Coordinated Care Model and support alternative payment methodologies; and
- Provide workgroup progress reports at least bi-annually to the Director of OHA and the Board.

The timeline outlines the deliverables that this group is required to produce.

Comments:

- It would be helpful to release the Model RFP template in spring 2015 or earlier than stated on the timeline. OEBC is planning to release an RFP in 2015, possibly in June.

3. Review of key elements of the Coordinated Care Model (CCM) and implementation status

Kelly introduced Jeanene Smith, the Administrator and Medical Director of the Oregon Health Authority, who provided an overview of Oregon’s Health System Transformation and the Coordinated Care Model. She outlined the principles of the model and the progress of model implementation in Medicaid.

Comments:

- A member asked whether there is commonality in metrics used for Medicaid and PEBB.
 - The Health Plan Quality Metrics Workgroup produced recommendations on the alignment of metrics that can be found at <https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf>.
 - Another member pointed out that population differences will definitely affect the metrics used to measure improvements.
- Kelly asked two of the members with CCM experience to comment on the model implementation and impact on their populations.
 - Both members with CCM experience noted that it was crucial to partner with providers, public health, and counties to implement the model in their delivery systems.
 - It has also been important to fully understand the population demographics to appropriately manage care and achieve improvements.
 - Provider transformation – changing the delivery of care – will be crucial to achieving true reform.

4. Group Discussion Questions

Kelly Ballas led the group in a discussion of the barriers, opportunities, and elements of importance of the CCM.

Comments:

- It will be important to figure out how to create demand and a strong value proposition for the CCM in the private sector.
- There are many small purchasers that do not go through an RFP process and work through brokers. It will be importance to ensure that the broker community understands the approach of the state, so that they can highlight the carriers that have implemented the CCM.
 - Broker education will be crucial to spread understanding of the model among the individual and small group market.
 - It was recommended that it might be useful to include a broker as a group member.
- Additionally, it will be important to educate consumers and health care purchasers about the CCM and explain the benefits of the model for health care delivery and overall health improvements.
 - There might be a misconception that the CCM is a model that restricts care and limits provider networks.
- Health insurance carriers and self-insured employers might be less inclined to adopt the model, since individuals often move between plans and carriers resulting in a loss of investment for the company.
 - Messaging the importance of investment across the health care system will be important.
 - Employers are interested in health improvements that are associated with spending trends, such as reductions in lost labor time.
 - Will need to have champions in the large and small group markets to spur adoption of the model.

5. Meeting schedule and next steps

Members were asked to formulate responses to a number of questions that will later inform the environmental scan. These responses will be discussed during the upcoming meeting.

Veronica will send out a Doodle poll to solicit dates and the frequency for future meetings. The next meeting is scheduled for Monday, September 29, 2014 from 10:30am – 12:30pm in the Oak Room of the Lincoln Building.

6. Public Comment

There was no public comment at this meeting.

Meeting was adjourned at 4:00pm.

**Oregon Health Policy Board
2014 Coordinated Care Model Alignment Workgroup
Members**

Laura Cali

Insurance Commissioner, Department of Consumer and Business Services, Insurance Division

Terry Coplin

CEO, Trillium Community Health Plan

Dan Forbes

Benefits Manager, OHSU

Marc Gonzales

CFO, Clackamas County Department of Finance

Denise Hall

Deputy Administrator, OEBC

Nora Leibowitz

Chief Policy Officer, Cover Oregon DHS

Kathy Loretz

Deputy Administrator, PEBB

Diane Lovell

Council Representative, AFSCME

Jesse O'Brien

Health Care Advocate, OSPIRG

Patrick O'Keefe

Partner/Account Manager, Cascade Insurance Center

Jordan Pape

Chief Executive Officer, The Pape Group, Inc

Robin Richardson

Senior Vice President, Moda Health

Sponsors and Staff:

Kelly Ballas

CFO, Oregon Health Authority (OHA)

Jeanene Smith, MD

Administrator, OHA, Office for Oregon Health Policy and Research (OHPR)

Lisa Angus

Policy Director, OHPR

Veronica Guerra
Policy Analyst, OHP

Fritz Jenkins
Administrator, Designated State Health Program

Coordinated Care Model (CCM) Alignment Workgroup Work Plan

2014

June

Workgroup membership approved by OHPB

August

1st workgroup meeting

- Focus: developing an understanding of the workgroup and the CCM

September

2nd workgroup meeting

- Focus: beginning the environmental scan: covered lives; carrier overlap; and existing alignment with the CCM among workgroup members

October

OHPB update on workgroup

3rd workgroup meeting

- Focus: continuing the environmental scan: cross walk of alignment efforts in PEBB, OEBC, and Cover Oregon

November

4th workgroup meeting

- Focus: finalizing the environmental scan and defining a vehicle for shared learning

December

5th workgroup meeting

- Focus: purchasing value and quality for Oregonians

2015

January

OHPB update on workgroup

Shared learning begins

6th workgroup meeting

- Focus: developing the framework for a model RFP

February

No meeting

March

Draft model RFP completed

7th workgroup meeting

- Agenda TBD

April

No workgroup meeting

May

Finalize model RFP

8th workgroup meeting

- Agenda TBD

June

Release model RFP to PEBB, OEBC, and Cover Oregon

9th workgroup meeting

- Agenda TBD

July

No workgroup meeting

August

10th workgroup meeting

- Agenda TBD

September

No workgroup meeting

October

11th workgroup meeting

- Agenda TBD

November

No workgroup meeting

December

12th workgroup meeting

- Agenda TBD

2016

January

No workgroup meeting

February

Shared learning ends

13th workgroup meeting

- Agenda TBD

March

No workgroup meeting

April

14th workgroup meeting

- Agenda TBD

May

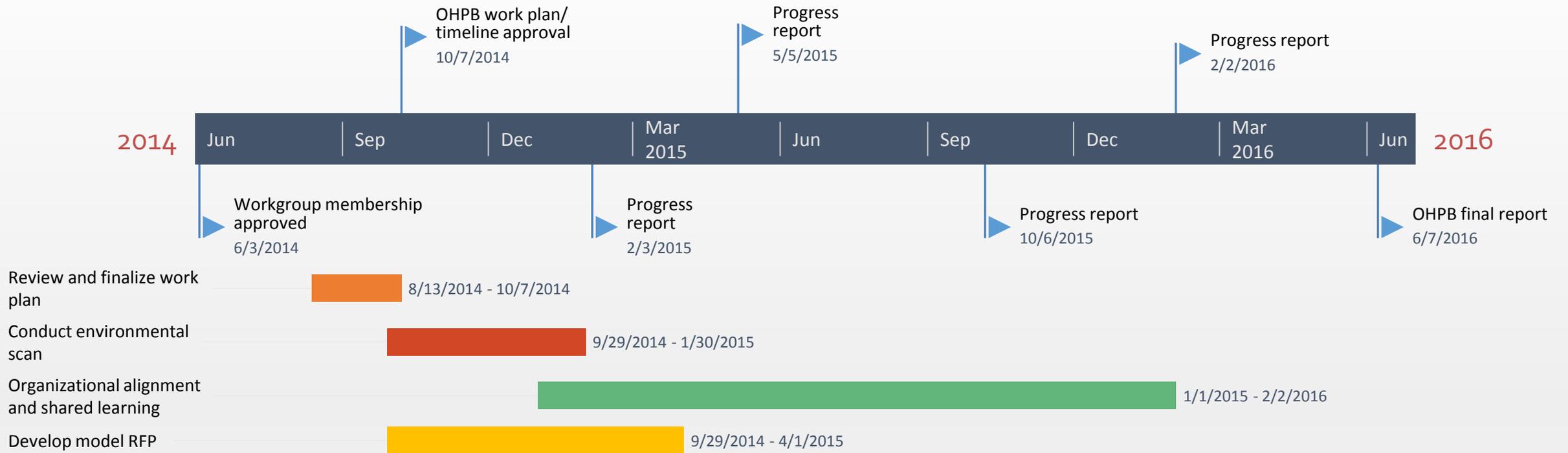
15th workgroup meeting

- Agenda TBD

June

Present the final recommendations to OHPB

DRAFT



Understanding the Extent of Innovative Purchasing Strategies across the Oregon Health Insurance Market

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. Ultimately, this workgroup aims to develop contract language, a model RFP, and other tools that incorporate principles of the CCM and health system transformation efforts (listed below).

The following questions are intended to help inform the environmental scan and the group's discussion of the CCM spread. We hope that members will review these questions and be prepared to share their individual responses during the second workgroup meeting. To understand the broad market needs for implementation of the CCM principles (listed below), please answer the following questions with your respective organization and market segment in mind:

1. What aspects of the CCM are important to your organization and market segment?
2. How can the CCM enhance your current health care purchasing or delivery strategies?
3. Please provide organizational examples of activities, programs, contract language and operations that already align with the six CCM principles outlined below. Are there additional examples that can be drawn from your market segment? Please provide sources for the examples provided.
4. Identify your organizational and market segment strengths, weaknesses, opportunities and threats in advancing the CCM principles.
5. What might be a reasonable timeline for your organization and broader market segment to implement some of these principles?
6. Are there other stakeholders and purchasers in your area you might draw into the conversation locally?
7. What would a strategic plan for implementation of the CCM look like from your perspective?

Principles of the CCM and health system transformation efforts:

1. Use best practices to manage and coordinate care

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

Examples:

- Single point of accountability
- Patient and family-centered care (e.g., patient-centered primary care homes - PCPCH)
- Increased coordinated care around long term care services and supports (LTSS)
- Team-based care across appropriate disciplines
- Cost containment and quality improvement plans to manage care for high-need, high-cost populations
- Plans for prevention and wellness, including addressing disparities among population served
- Broad adoption and use of electronic health records

2. Share responsibility for health

When providers, payers and consumers work together, health improvement becomes a team effort. An informed, engaged, and empowered patient/consumer can take on greater personal responsibility through shared decision-making for care and accountability for personal health behaviors.

Examples:

- Shared decision-making for care among members and providers
- Providers can increase member education about care management, personal health behaviors and treatment options
- Payers can support patients/consumers in becoming accountable for personal health behaviors through evidence-based wellness incentives (e.g., gym membership subsidies, smoking cessation programs, weight loss programs, etc.) and payment for preventive primary care

3. Measure performance

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

Examples:

- Establish shared metrics with clear targets and utilize across purchasers
- Share strategies for metrics improvement on quality, cost and access outcomes
- Network adequacy improvements (e.g., regional provider supply) resulting from measurement of performance metrics

4. Pay for outcomes and health

Alternative payment methodologies (APMs) – such as value-based payments, shared savings, and incentives for quality outcomes – support improved care delivery and quality of care, while providing flexibility that does not limit access to health care services.

Examples:

- Use of global budgets to cover the total cost of care for members
- PCPCH tiered payment structure
- Value-based payments to providers

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

Readily available, accurate, reliable and understandable information about the price and quality of care can help members understand health care plan choices and share responsibility in treatment and care management. Increased transparency can also lead to improved provider accountability.

Examples:

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

6. Establish a sustainable rate of growth

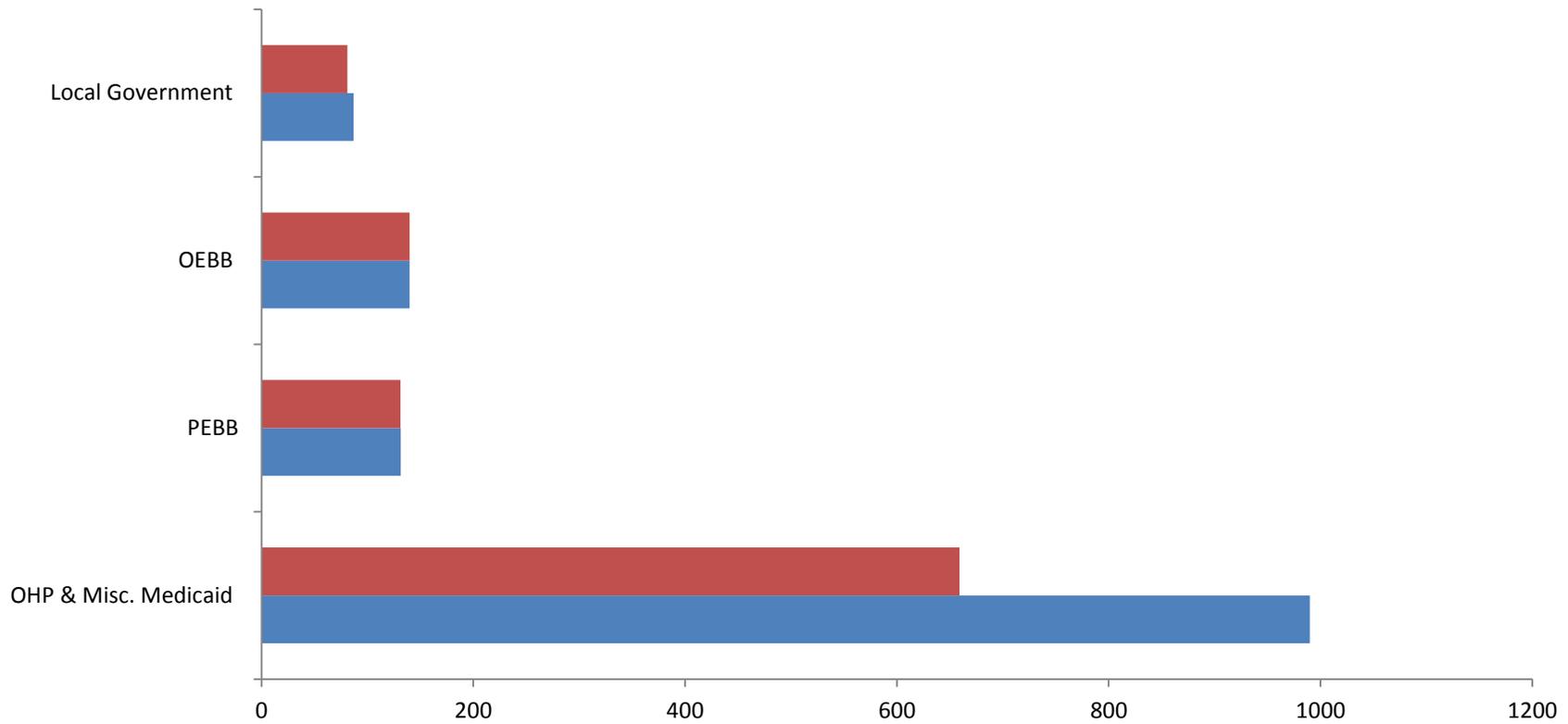
Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through the establishment of a fixed rate of growth is foundational to health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

Examples:

- Improving care coordination at all levels in the health care system
- Integrating care delivery budgets across the spectrum
- Spread of effective and evidence-based delivery system and payment innovations

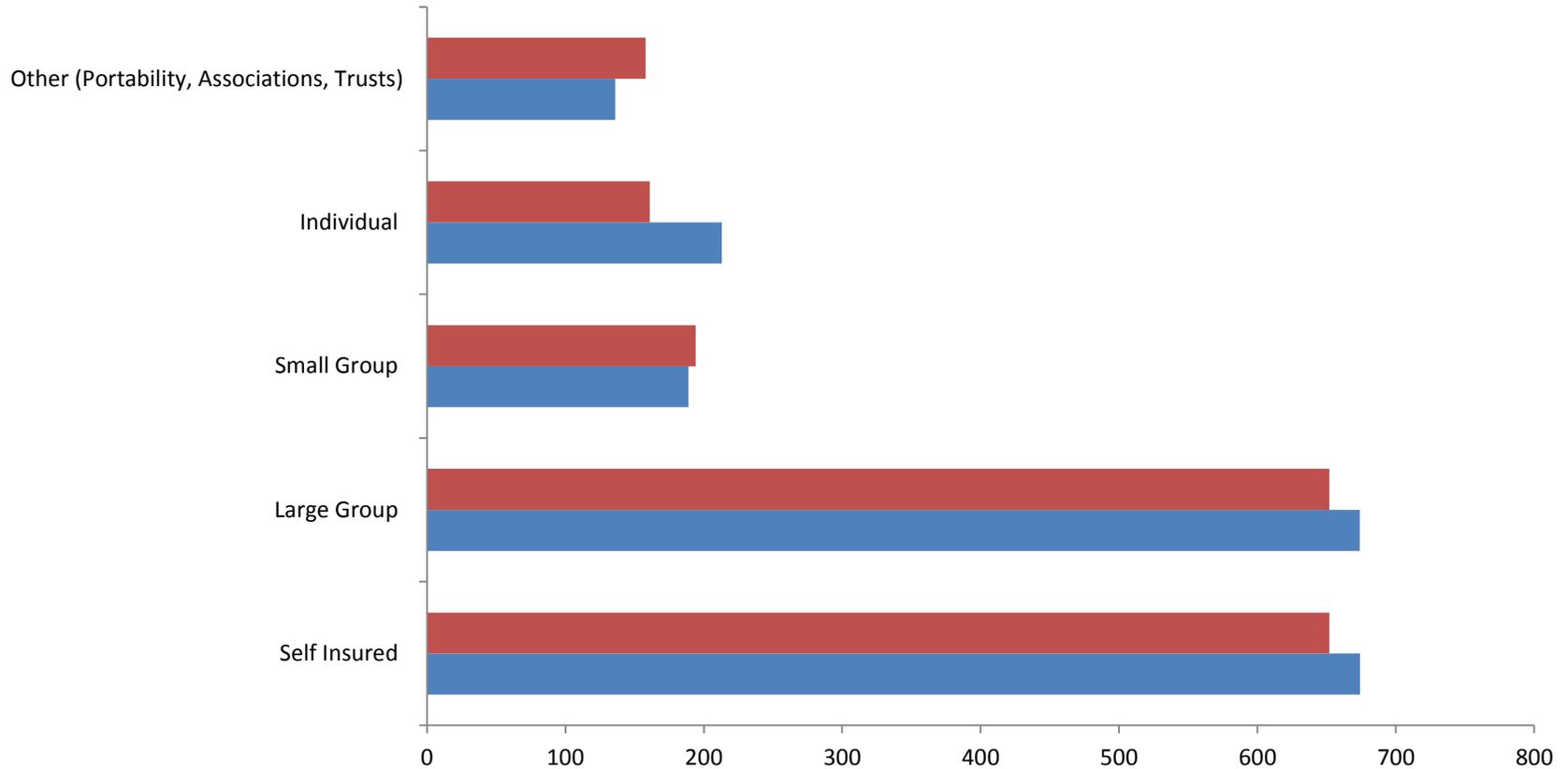
Enrollment in Oregon Health Insurance Market Segments

Enrollment: Public Purchasers



	OHP & Misc. Medicaid	PEBB	OEGB	Local Government
2013 Q4	659000	131161	139896	81151
2014 April	990000	131300	139815	86900

Enrollment: Commercial Insurance



	Self Insured	Large Group	Small Group	Individual	Other (Portability, Associations, Trusts)
■ 2013 Q4	651884	652000	194000	161000	158000
■ 2014 Q1	674150	674000	189000	213000	136000

Overlap Among Carriers Participating in Health Insurance Market

Carrier Name	Cover Oregon	Individual	Small Group	Large Group*	Oregon Health Plan/Medicaid	Medicare Advantage	PEBB	OEBB
Aetna Life Insurance Company				X				
Atrio Health Plans, Inc.	Service areas: 4 counties in Regions 2-4	Service areas: 4 counties in Regions 2-4	Service areas: 4 counties in Regions 2-4		Through partnership with Umpqua Health Alliance CCO (Service area: 1 county in Region 3) and Willamette Valley Community Health CCO (Service areas: 2 counties in Region 2)	Service areas: 4 counties in Regions 2-4		
AllCare Health Plan, Inc.					Service areas: 4 counties in Region 3			
BridgeSpan Health Company	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5						
CareOregon, Inc.	Through Oregon's Health CO-OP Service areas: All counties in Regions 1-5				Through partnership with Columbia Pacific CCO (Service area: 4 counties in Regions 2-3); Health Share of Oregon CCO (Service area: 3 counties in Region 1); Jackson Care Connect CCO (Service area: 1 county in Region 3); PrimaryHealth Josephine County CCO (Service areas: 3 counties in Region 3); and Yamhill CCO (Service areas: 5 counties in Regions 1-2)	Through CareOregon Advantage Service areas: 9 counties in Regions 1-3		
Cascade Health Alliance CCO					Subsidiary of Cascade Comprehensive Care, which was a founding partner for Atrio Health Plans Service area: 1 county in Region 4			
Cigna Health and Life Insurance Company				X				
Connecticut General Life Insurance Company				X				
FamilyCare Health Plans, Inc.					Through FamilyCare Health Plans CCO Service area: 4 counties in Regions 1-2	Service areas: 6 counties in Regions 1-2 and 5		
Health Net Health Plan of Oregon	2014 service areas: 3 counties in Region 1 (Off Exchange starting in 2015)	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	X		Service areas: 13 counties in Regions 1-3		
Health Republic Insurance (Freelancers CO-OP)	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5					
Humana Insurance Company						Also through Humana Health Plan Service areas: 13 counties in Regions 1-2 and 4-5		
Kaiser Foundation Health Plan of the Northwest	Service areas: 10 counties in Regions 1-2	X	Service areas: 30 counties in Regions 1-5	X	Through Kaiser Permanente OR Plus and partnership with Health Share of Oregon (Service area: 3 counties in Region 1)	Through Kaiser Permanente Service areas: 9 counties in Region 1-2	Service areas: 11 counties in Regions 1-2	Service areas: 11 counties in Regions 1-2
LifeWise Health Plan of Oregon	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	X				
Mid Rogue Health Plan						Through CareSource health plan Service areas: 3 counties in Region 3	Service areas: 3 counties in Region 3 (carrier participating beginning in 2015)	
Moda Health Plan, Inc.	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	X	Through partnership with Eastern Oregon CCO Service areas: 12 counties in Regions 4-5	Service areas: All counties in Regions 1-5	Service areas: 24 counties in Regions 1-2 and 4-5 (carrier participating beginning in 2015)	Service areas: All counties in Regions 1-5
Oregon's Health CO-OP	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	X				
PacificSource Health Plans	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	X	Through PacificSource Community Solutions CCO Service areas: 6 counties in Regions 1 and 4	Through PacificSource Medicare Service areas: 13 counties in Regions 1-5		
Providence Health Plan	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	X	Through partnership with Elder Place Program and Health Share of Oregon (Service area: 3 counties in Region 1)	Service areas: 8 counties in Regions 1-2	Service areas: All counties in Regions 1-5	
Regence Blue Cross Blue Shield		Service areas: All counties in Regions 1-5	Service areas: All counties in Regions 1-5	X		Service areas: 18 counties in Regions 1-3		
Samaritan Health Plans, Inc.			Service areas: 3 counties in Region 2		Through partnership with InterCommunity Health Network CCO Service areas: 3 counties in Region 2	Through Samaritan Advantage Health Plan Service areas: 3 counties in Region 2		
Time Insurance Company		Service areas: All counties in Regions 1-5						

Carrier Name	Cover Oregon	Individual	Small Group	Large Group*	Oregon Health Plan/Medicaid	Medicare Advantage	PEBB	OEBB
Trillium Community Health Plan, Inc.	Service areas: 3 counties in Region 2 (starting in 2015)	Service areas: 3 counties in Region 2 (starting in 2015)	Service areas: 3 counties in Region 2 (starting in 2015)		Service areas: 1 county in Region 2	Service areas: 1 county in Region 2	Service areas: 1 county in Region 2 (carrier participating beginning in 2015)	
United Healthcare Insurance Company			Service areas: All counties in Regions 1-5	X		Through UnitedHealth Group Service areas: 9 counties in Region 1-2		
UnitedHealthcare of Oregon, Inc.			Service areas: 9 counties in Regions 1-2	X				
Western Oregon Advanced Health CCO					Service areas: 2 counties in Region 3			

Carrier Service Areas by Region		
Region 1	Portland Metro	Clackamas, Hood River, Multnomah, and Washington Counties
Region 2	Willamette Valley, North and Mid-Coast	Clatsop, Columbia, Tillamook, Yamhill, Polk, Marion, Lincoln, Linn, Benton, and Lane Counties
Region 3	Southern Oregon and South Coast	Douglas, Curry, Coos, Joesphine and Jackson Counties
Region 4	Central Oregon	Wasco, Sherman, Gilliam, Jefferson, Wheeler, Crook, Deschutes, Lake and Klamath Counties
Region 5	Eastern Oregon	Morrow, Umatilla, Union, Wallowa, Baker, Grant, Harney and Malheur Counties

* Service areas for large group carriers were unavailable at time information was compiled.
Note: Only those CCOs that provide medical services and are considered a plan are listed. For those who have partner organizations, the CCO is identified under the partner organization's name above.
Note: This analysis excludes TPAs, carriers without major medical plans filed in Oregon, and carriers with discontinued products or who have withdrawn from the market.

Coordinated Care Organization (CCO), Public Employees' Benefit Board (PEBB), and Oregon Educators Benefit Board (OEBB) Alignment with Coordinated Care Model (CCM) Principles

Oregon's coordinated care vision can be broken into six basic principles that will serve as the compass for health system transformation. This document attempts to provide an overview of CCO, PEBB, and OEBB efforts to align activities, programs, and operational aspects with individual CCM principles to further transformation efforts. The examples listed below are not exhaustive, and are meant to provide high-level examples of activities found in carriers' contract language. The CCM principles are defined below:

1. **Use best practices to manage and coordinate care:** Coordinating care through evidence-based best practices can support providers and health care facilities in attaining the highest quality of care in the most efficient manner.
2. **Share responsibility for health among patients, providers, and plans:** When providers, payers and consumers work together, improving health becomes a team effort. An informed, engaged, and empowered patient/consumer can take on greater personal responsibility through shared decision-making for care and accountability for personal health behaviors.
3. **Provide information so that patients and providers know price and quality data:** Readily available, accurate, reliable and understandable cost and quality data can help patients understand health care plan choices, and share responsibility in treatment, care management, and other health care decisions. Increased transparency on price and quality can also lead to increased accountability for providers.
4. **Measure performance:** Strengthening performance measurement alignment across purchasers eases the burden of reporting for providers and establishes an accurate picture of health and performance outcomes.
5. **Pay for outcomes and health:** Alternative payment methodologies (APMs) such as value-based payments, shared savings, and offering incentives for quality outcomes instead of volume based fee methodologies supports better care and better quality of care while providing flexibility without compromising access to care or services.
6. **Maintain costs at a sustainable rate of growth:** Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through a fixed rate of growth approach is foundational to health care transformation in Oregon.

For brevity purposes and due to overlap, CCM principles 2 & 3 and 4 & 5 have been grouped together in the charts below.

Principle 1: Use best practices to manage and coordinate care				
Possible Transformation Element	CCO	PEBB	OEBB	Additional Market Segments
1. Care coordination	<ul style="list-style-type: none"> Support the appropriate flow of information and identify a care team to manage care and coordinate services Coordinate with social and support services and residential addictions and MH service providers 	<ul style="list-style-type: none"> Coordination with other services providers (e.g., vision) Discharge planning services 	<ul style="list-style-type: none"> Pharmacy benefit management care coordination for members in case & disease management 	
2. Patient centered models of care	<ul style="list-style-type: none"> Increase the number of enrollees served by PCPCHs; support movement along spectrum of the PCPCH model; and assist existing providers to establish PCPCHs Assist other providers to communicate and coordinate care with PCPCH using electronic health information technology 	<ul style="list-style-type: none"> Support the medical home concept by increasing PCPCHs 	<ul style="list-style-type: none"> Assist providers to establish PCPCHs 	
3. Physical, behavioral health & addiction services integration	<ul style="list-style-type: none"> Use evidence-based, innovative strategies that support a continuum of care that integrates MH, PH, addiction treatment, dental health interventions seamlessly and holistically 	<ul style="list-style-type: none"> Reporting on efforts to better coordinate MH/BH with PH services Value tier medications for certain medical, MH/BH conditions 	<ul style="list-style-type: none"> Reporting on efforts to better coordinate MH/BH with PH services 	
4. Programs for complex care needs	<ul style="list-style-type: none"> Provide case management services to those with complex medical needs 	<ul style="list-style-type: none"> Large case management services and disease management programs 	<ul style="list-style-type: none"> Pharmacy benefit management Disease care management and case management program 	
5. Health information technology & health information exchange	<ul style="list-style-type: none"> Adoption and meaningful use of EHRs Set goals for transformational elements of HIT (e.g., analytics, quality reporting, patient engagement) Facilitate health information exchange that supports a value-based delivery system 	<ul style="list-style-type: none"> Increase use of EMRs and the electronic exchange of health information Telehealth programs (e.g., Providence Health eXpress) 	<ul style="list-style-type: none"> Diabetes treatment telemedical services and if medically necessary for other conditions 	

Principles 2 &3: Share responsibility for health among patients, providers, and plans; and provide information so that patients and providers know price and quality data

Possible Transformation Element	CCO	PEBB	OEBB	Additional Market Segments
1. Clinical care improvement	<ul style="list-style-type: none"> Promotion of recommended screenings Develop and operate a quality assurance and performance improvement program CCO and hospital quality pool 	<ul style="list-style-type: none"> Participate in the Quality Corporation’s Aligning Forces for Quality initiative and adopt guidelines for specific conditions Guidelines and language around hospital acquired conditions 	<ul style="list-style-type: none"> USPSTF A and B recommended preventive services Participate in Oregon Healthcare Quality Corporation’s initiative and participate in eValue8 	
2. Patient engagement in health improvement	<ul style="list-style-type: none"> Provide health risk assessment and distribute educational materials on health lifestyles and chronic disease treatment and self-management Engage the Community Advisory Council to monitor patient engagement and activation 	<ul style="list-style-type: none"> Better choices, better health (online self-management program) Fitness facility subsidy Weight management program Health Engagement Model 	<ul style="list-style-type: none"> Healthy Futures wellness tools and programs On-site/online team based worksite wellness program MoodHelpers (online cognitive behavioral treatment) 	
3. Improving transparency & providing decision making information	<ul style="list-style-type: none"> Community Advisory Council Community Health Assessment and Health Improvement Plan 	<ul style="list-style-type: none"> Online tools for shared decision making Medical plan cost calculator Hospital transparency and access to health care information 	<ul style="list-style-type: none"> Case management program: web-based and non-web-based decision support tools that compare treatment options Moda cost calculator Leap Frog (hospital transparency) 	

Principles 4 &5: Measure performance; and pay for outcomes and health				
Possible Transformation Element	CCO	PEBB	OEBB	Additional Market Segments
1. Differential payment for providers (or carriers) based on performance	<ul style="list-style-type: none"> No payment for health acquired conditions obtained in a facility Payments to hospitals for bundles of care CCO and hospital quality pool 	<ul style="list-style-type: none"> 42 performance measures with premiums/fees at risk (future) No payment for hospital acquired conditions Tiered payment for PCPCHs 	<ul style="list-style-type: none"> No payment for hospital acquired conditions Tiered payment for PCPCHs 	
2. Alternative payment methodologies	<ul style="list-style-type: none"> Implement a schedule of alternative payments, including alternative payments and incentives for PCPCHs 	<ul style="list-style-type: none"> Pay for performance program (Providence) Develop models that include withhold, global budgets, capitation, and other reimbursement based on PCPCHs 	<ul style="list-style-type: none"> Endorse innovative models that move away from fee-for-service, including withhold, global budgets, and capitation 	
3. Measuring and monitoring care and service	<ul style="list-style-type: none"> Participate in the All Payers All Claims Reporting system Quality pool based on outcome and quality measure improvement 	<ul style="list-style-type: none"> Targeted monitoring of c-section rates, hospital admission rates, HEDIS measures, and member satisfaction 	<ul style="list-style-type: none"> Targeted monitoring of c-sections, elective inductions, post-hospitalization, HEDIS and CAHPs measures Measurement reporting to Strategies and Evidence-based Outcomes Workgroup 	

Principle 6: Maintain costs at a sustainable rate of growth				
Possible Transformation Element	CCO	PEBB	OEBB	Additional Market Segments
1. Administrative simplification/waste reduction	<ul style="list-style-type: none"> Implement an administrative performance standard with a 1% withhold 	<ul style="list-style-type: none"> 21 administrative performance measures with premiums at risk 	<ul style="list-style-type: none"> Participate in state administrative simplification efforts 	
2. Cost containment programs and budget increase limitations	<ul style="list-style-type: none"> Global payment for all covered services Reduce per member, per month cost trend 2 percentage points by FY 2015 	<ul style="list-style-type: none"> 3.4% budget limitation 	<ul style="list-style-type: none"> Cost containment program to replace high cost services with lower cost services Develop other innovative cost containment programs that ensure appropriate, cost-effective care 	

Coordinated Care Model (CCM) Alignment Environmental Scan

Introduction

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 an environmental scan.

Purpose:

The environmental scan aims to develop a more comprehensive picture of Oregon's health insurance market environment and the characteristics of its individual market segments, including 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 environmental scan will also assist in developing a framework for the model RFP.

Areas of interest for environmental scan:

- Carrier programs/operations supporting the CCM;
- 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.

Process:

To gather information for the environmental scan, OHPR staff will rely on members of the Coordinated Care Model Alignment Workgroup to provide input on obtaining responses and identifying individuals/carriers for survey completion. To begin, the survey will be circulated to carriers that participate in three or more market segments and have the largest number of covered lives. OHPR staff will interview carriers to further understand activities and programs in place and the barriers and opportunities for further spread of the CCM across a greater group of payers. Interviews may take place with any combination of the following individuals from each carrier organization— contracts coordinators; government programs representative; Chief Operating Officers; and Chief Executive Officers.

Additionally, OHPR staff can use the Oregon Coalition of Health Care Purchasers, Oregon Association of Health Underwriters, and the Oregon Health Leadership Council as additional resources to obtain broad participation. These organizations can serve as a resource to connect OHPR staff to the appropriate individual within each health plan and later serve as a platform to disseminate information about the CCM.

Instructions for completion:

Please enter a score ranging from 0 to 4 that reflects the best description of the status of your organization's effort to adopt the activities listed, which are considered to be critical components of the Coordinated Care Model and health system transformation. In addition to providing a numerical score, please provide examples that illustrate the activities, programs, or benefits that support each element.

Use the following explanation of the scale to guide your responses:

0 – **No activity:** the carrier has not started any activity related to this activity.

1 – **Exploring / planning:** the carrier is conducting activities related to assessment of the issue and possible approaches, including background research, data collection, gap analysis, identification of innovative programs, and/or stakeholder assessment.

2 – **Designing:** the carrier is designing a specific approach to implementing the particular activity. Design activities include, but are not limited to, developing the program definition, defining procedures and processes, designing evaluation or assessment strategies, and identifying desired outcomes.

3 – **Implementing / revising:** the carrier has implemented the activity in at least one setting. Implementation activities include, but are not limited to, implementing processes and activities, establishing a process evaluation and, if appropriate, data collection and review. Revising the program or activity based on the feedback or results from the initial implementation also counts as implementation.

4 – **Final implementation and plan to scale:** using information and data from the implementation phase, the carrier has finalized the initiative and is identifying options for bringing the initiative to scale or has already scaled the initiative across its provider networks.

Survey Tool

Name of carrier:	
Market segments served (e.g., small group, PEBB, Cover Oregon):	
Number of covered lives:	
Name, position, and email of individual completing survey:	
Date of completion:	

Activity, Program, Benefit	Status as of October 2014 (for each item, enter a score of 0 to 4 in the applicable column)				
	No activity	Exploring/ planning	Designing	Implementing / revising	Final implementation & plan to scale
	0	1	2	3	4
Use best practices to manage and coordinate care.					
1. How would you describe your progress on implementing strategies to ensure care coordination and continuity of care for members, especially for individuals with complex needs (e.g., dual eligibles, SPMI population)?					
a. Describe one or more examples of efforts at the carrier level to ensure care coordination.					
2. How would you describe your progress on encouraging patient centered models of care among providers (e.g., patient centered primary care homes)?					
a. Describe one or more examples of incentives that have been provided to make the model as effective as possible and to encourage the further development of PCPCHs.					
3. How would you describe your progress on implementing integration of physical health, behavioral health, and addictions services?					
a. Describe one or more innovations that have been adopted to integrate these services.					

Activity, Program, Benefit	Status as of October 2014 (for each item, enter a score of 0 to 4 in the applicable column)				
	No activity	Exploring/ planning	Designing	Implementing / revising	Final implementation & plan to scale
	0	1	2	3	4
4. How would you describe your progress on implementing population-based programs for high-risk members (e.g., case management, disease management, pharmacy benefit management)?					
a. Describe one or more examples of interventions that have improved member health outcomes.					
5. How would you describe your progress on implementing health information technology solutions that foster increased access among providers, sharing of relevant clinical information, or ensure that providers meet meaningful use standards?					
a. Describe one or more innovations that have been adopted related to HIT (e.g., certified electronic health records, health information exchange, telehealth programs).					
Share responsibility for health among patients, providers, and plans and provide information so that patients and providers know price and quality data.					
1. How would you describe your progress implementing clinical care improvement efforts (e.g., evidence-based clinical guidelines, patient safety protocols, quality improvement initiatives)?					
a. Describe one or more innovations that have been adopted related to clinical care improvement.					
2. How would you describe your progress implementing programs that encourage engagement of members in the improvement of their health (e.g., individual and work-site wellness programs, online tools)?					
a. Describe one or more adopted programs that have resulted in improved health outcomes.					

Activity, Program, Benefit	Status as of October 2014 (for each item, enter a score of 0 to 4 in the applicable column)				
	No activity	Exploring/ planning	Designing	Implementing / revising	Final implementation & plan to scale
	0	1	2	3	4
3. How would you describe your progress implementing programs that improve transparency and provide decision-making information to members (e.g., provider and price comparisons)?					
a. Describe one or more programs that have been adopted to improve transparency.					
Measuring performance and paying for outcomes and health.					
1. How would you describe your progress implementing differential payment for providers based on performance (e.g., hospital acquired conditions, readmissions, C-section rate and elective deliveries before 39 weeks)?					
a. Describe one or more efforts to differentiate providers who meet or exceed standards for quality and efficiency.					
2. How would you describe your progress on moving away from fee-for-service models and implementing alternative payments, such as those that incorporate risk (e.g., shared savings arrangements, global payments, bundled payments)?					
a. Describe one or more payment reform efforts and alternate payment methodologies and measures.					
3. How would you describe your progress on implementing mechanisms to monitor and measure dimensions of care and service (e.g., HEDIS, CAHPS)?					
a. Describe one or more efforts to measure quality of care and member satisfaction.					

Activity, Program, Benefit	Status as of October 2014 (for each item, enter a score of 0 to 4 in the applicable column)				
	No activity	Exploring/ planning	Designing	Implementing / revising	Final implementation & plan to scale
	0	1	2	3	4
Maintain costs at a sustainable rate of growth.					
1. How would you describe your progress on simplifying administrative tasks, streamlining processes, or reducing waste?					
a. Describe one or more innovations that have been adopted to achieve administrative simplification and reduce waste.					
2. How would you describe your progress on implementing cost containment programs or other budget increase limitations that do not adversely affect access and quality of care?					
a. Describe one or more programs that have contained costs and controlled the spending trend.					

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