

## Oregon Health Policy Board

### AGENDA

October 11, 2011

Market Square Building

1515 SW 5th Avenue, 9th floor

1:00 pm to 5:00 pm

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

	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll call Consent agenda: <ul style="list-style-type: none"> <li>• 09/13/11 minutes</li> <li>• Public Employers Health Purchasing Committee member change</li> </ul>	Vice- Chair, Lillian Shirley	X
2	1:05	Director's Report	Bruce Goldberg	
3	1:15	<ul style="list-style-type: none"> <li>• Medical Assistance Program (MAP) Update</li> <li>• PEBB/OEBB Update</li> </ul>	Judy Mohr Peterson Joan Kapowich	
4	1:30	Work Group Feedback – What happened in September and what's happening next: <ul style="list-style-type: none"> <li>• Coordinated Care Organization Criteria</li> <li>• Global Budget Methodology</li> <li>• Outcomes, Quality and Efficiency Metrics</li> <li>• Integration of care for people dually eligible for Medicare and Medicaid</li> </ul>	Board Members Tina Edlund	
5	2:15	Oregon Health Policy Board Product to the Legislature: <ul style="list-style-type: none"> <li>• What will CCOs <i>look like</i>?</li> </ul>	Board Discussion	
	3:00	Break		
6	3:15	State of Equity Report	Tricia Tillman Julie Maher	
7	3:45	Public Testimony	Vice- Chair, Lillian Shirley	
8	5:00	Adjourn		

### Upcoming

**November 8, 2011**

**Market Square Building**

**8:00 am to 12:30 pm**



**Oregon Health Policy Board**  
**DRAFT Minutes**  
**September 13, 2011**  
**8:00am – 12:30pm**  
**Market Square Building**  
**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**  
**Portland, OR 97201**

Item
<p><b>Welcome and Call To Order</b> Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. Joe Robertson, Nita Werner, Eileen Brady, Felisa Hagins, and Carlos Crespo arrived after the meeting was called to order. Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p>
<p><b>Consent Agenda was moved back in order to wait for a quorum to be reached.</b></p>
<p><b>Director's Report – Dr. Bruce Goldberg</b> Dr. Goldberg spoke about health system transformation. The HB 3650 work groups are up and running. Governor Kitzhaber, Mike Bonetto, and Bruce Goldberg have been speaking regularly with CMS, and feel as though CMS understands where we are going and is engaged and ready to help.</p> <p>Jeremy Vandehey spoke briefly about upcoming community meetings. The meetings will be mainly focused on collaborating with local communities and discussing how to make CCOs work best on a local level.</p> <p><i>The Director's Report can be found <a href="#">here</a>, starting on page 5. More information on the Community Meetings can be found at <a href="http://www.health.oregon.gov">www.health.oregon.gov</a>.</i></p>
<p><b>Medicaid Update – Judy Mohr Peterson presented by phone</b></p> <ul style="list-style-type: none"><li>• The usual Medicaid dashboard will be presented quarterly from now on.</li><li>• In the process of implementing OHP budget reductions.</li><li>• Update on the March of Dimes program, and the effort to improve quality outcomes by putting a “hard stop” to elective, non-medically necessary induction or C section prior to 39 weeks.</li></ul> <p><i>You can see Bruce Goldberg's letter to providers asking for support on March of Dimes <a href="#">here</a> on page 9, or go to <a href="http://www.marchofdimes.com/39weeks">www.marchofdimes.com/39weeks</a> for more information.</i></p>
<p><b>PEBB/OEBB Update – Joan Kapowich presented by phone</b> There will be a joint PEBB/OEBB board meeting on September 22 that will focus on the Health Transformation timeline and how we will be fitting in with CCOs and the overall Transformation timeline. There should be a report in October on the timeline.</p>
<p><b>Consent Agenda (8:28):</b> Quorum was reached and minutes from the August 9, 2011 meeting were unanimously approved.</p>
<p><b>Mental Health Services Update – Richard Harris, OHA Addictions and Mental Health</b> Richard Harris gave a presentation on the future of mental health and how it will fit into the future system of care. He described the future system as being a connected network between providers, Coordinated Care Organizations, and Local Mental Health Authorities (LMHAs).</p> <p><i>The Addictions and Mental Health presentation can be found <a href="#">here</a> starting on page 11.</i></p>
<p><b>Oregon Health Leadership Council update – Greg Van Pelt, Providence Health &amp; Services</b> The Oregon Health Leadership Council was commissioned by the business community in 2008 to develop solutions and actions to keep health care costs and premium increases closer to CPI. Greg Van Pelt presented on the progress of the Oregon Health Leadership Council's “Big Idea,” a program to develop new models of community based care delivery that are much in line with OHA's Transformation work.</p> <p><i>The OHLC “Big Idea” presentation can be found <a href="#">here</a> starting on page 25.</i></p>
<p><b>Work Group Feedback – Tina Edlund</b> Tina Edlund reviewed the outcomes from the first set of work group meetings that took place during August:</p>

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

The summaries from those four meetings can be found [here](#) starting on page 33.

For each work group, the board liaison gave a report on the meeting, Tina gave a review of the discussions, and the Board members were asked to give feedback on what was said and the direction of the work group, including what the Board agreed with and what the Board hoped to see more emphasis placed on or more deliberation held.

The Board's feedback can be found [here](#), from pages 33-56.

#### **Oregon Health Policy Board Product to the Legislature – Diana Bianco**

Diana Bianco discussed what the Board's final product to the legislature in February will look like. The board discussed how to take all this information and put it into one product that can be taken to the Legislature?"

The OHPB will be responsible in February for delivering the following to the Legislature:

- Draft legislative language for implementation of CCOs
- A business plan for CCO development
- Medical liability/cost containment strategies
- Standards for specified health care workers: community health workers, peer wellness specialists, personal health navigators.

Diana's presentation, with questions, can be found [here](#) on page 59.

#### **Public Testimony**

The board heard public testimony from two people:

- John Mullen, from the Oregon Law Center, spoke about long term care services integration, and health equity.
- Donna Royal spoke on behalf of his mother, who had sustained and suffered abuse from Oregon hospitals, and how important it is that the state of Oregon be sure to have a safe and trustworthy care system for all Oregonians. *His written testimony can be found [here](#).*

#### **Adjourn**

#### **Next meeting:**

**October 11, 2011**

**1:00 pm to 5:00 pm**

**Market Square Building**

**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**

**Portland, OR 97201**

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**Monthly Report to  
Oregon Health Policy Board  
October 11, 2011**

*Bruce Goldberg, M.D.*

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**PROGRAM AND KEY ISSUE UPDATES**

**Healthy Kids Program**

- Through August 2011, **98,300** more children have been enrolled into Healthy Kids for a total child enrollment of **368,373**.
- **5,626** of these children are now enrolled in Healthy KidsConnect.
- This is 123% of our goal of 80,000 more children and a 36% increase in enrollment since June 2009 (baseline).
- *See the chart below for a more detailed look at Healthy Kids enrollment.*

**OHP Standard**

- The 2011/2013 biennial goal is to have an average monthly enrollment of 60,000 individuals enrolled in OHP Standard. This goal has been carried over from the 2009/2011 biennium.
- As of August 15, 2011, enrollment in OHP Standard is now **66,782**.
- There have now been twenty random drawings to date. The last drawing was on September 7, 2011 for 2,500 names. The next drawing will occur on October 5, 2011 for 3,500 names.

**Community Meetings**

For the past two weeks state legislators, Oregon Health Policy Board members and OHA staff traveled across the state talking with local communities about Coordinated Care Organizations. The purpose of the community meetings is to spread the word about the goals of CCOs and to invite new ideas about how CCOs would best work locally. At each meeting so far, there has been a wide range of people – providers of all kinds, advocates, clients, and representatives from the counties. Issues that have been coming up frequently include prevention, local control and accountability, need for flexibility to accommodate localities, patient responsibility, addictions and mental health care, and a strong drive to focus on early investments to avoid expensive hospital costs.

There are still two community meetings remaining: Eugene tomorrow evening and Astoria on Thursday evening. We are taking extensive notes of the comments and will be providing those to Board members at completion of meeting cycle.

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A review of the community meetings, a newspaper article covering the Medford meeting, and the community meetings flier are all attached to the Director's Report.

**Governor John Kitzhaber in Washington D.C.**

Last week, Governor Kitzhaber gave a keynote address to the 2011 Medicaid Managed Care Conference in Washington D.C. The speech called on Congress to reframe the debate over Medicaid, Medicare and the national debt and look to states for new models to improve health care while reducing cost in a keynote address to the 2011 Medicaid Managed Care Conference in Washington D.C.

You can read the full press release [here](#) or by going to the Governor's website.

**September Legislative Days**

The Oregon Senate and House health care committees held a joint committee hearing on September 22nd from 8 to 11:00 a.m. Mike Bonetto, Eric Parsons, Lillian Shirley, Chuck Hofmann and I presented an update on HB 3650 work groups and the transformation work that has been progressing since the 2011 session ended. More details on that today at our meeting.

The interim committees will meet two more times before the 2012 legislative session, in November and January.

**Quarterly Health Insurance Rate Increases Released.**

Go to <http://www.oregonhealthrates.org/> and click on the Recent Rates tab to find out more.

**Upcoming**

**Next OHPB meeting:**

**November 8, 2011**

**8:30 AM to 12:00 PM**

**Market Square Building**

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



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**Report on community meetings  
October 5, 2011**

As of Wednesday morning more than 375 people came to community meetings in Roseburg, Medford & Pendleton. Coming up this week yet we have Florence and Bend. Next week Portland, Eugene and Astoria. We have had full houses in all the meetings so far.

The format of the meetings included a presentation about the vision of CCOs and also in most locations a presentation from a local provider innovating on coordinated care. In Roseburg that was Dr. Bob Dannenhofer of DCIPA. In Medford it was Dr. Barry Hamann, a family practice doctor. In Pendleton OHPB member Dr. Chuck Hofmann was able to join us as was Renee Grandee, also a family practice doctor. We also left a lot of time for Q/A and had small break out sessions to focus on three questions:

- What was the best health care experience you've had. What were the key features that made it the best?
- What is the responsibility of the patients to be active participants in their care plans?
- Coordinated Care organizations need to be accountable to and engage the community they serve. (Two parter) How should that accountability happen and how would we know that they are engaging the communities they serve in a meaningful way?

Attendees to the meetings went beyond the people we normally see at public meetings about health care and included lawmakers, clients, providers of all sorts, home health care workers, health care advocates, public health advocates, tribes, county representatives, and representatives from health plans. In each location there was also wide media coverage in the local paper, radio and TV where it was available.

While people had many questions about the details of CCOs, there was wide agreement about the vision and goals. The small group conversations were robust and positive.

We are compiling the Q/A from each meeting and highlighting common themes, which will be sent to the Board as a packet after the final meeting is finished.

The two remaining meetings are:

**Eugene:**

October 12, 6-8:00 p.m.  
Campbell Senior Community Center  
155 High Street  
Eugene, OR 97401

**Astoria:**

October 13, 6-8:00 p.m.  
[Clatsop Community College](#)  
Columbia Hall, Room - Columbia 219  
1651 Lexington Ave., Astoria, OR 97103

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## Oregon Health Plan to be streamlined, officials say

*State officials say the goal of a bill passed by the Legislature is to reduce pricey tests and focus on preventive treatment.*

By [Chris Conrad](#)

Mail Tribune

September 28, 2011 2:00 AM

State health officials had some bad and good news for a crowd of around 120 that gathered Tuesday night at the Santo Community Center in Medford to hear about possible changes to the Oregon Health Plan coming next year.

The bad news, they said, is the state's health care system is seriously ill and costing taxpayers millions in waste and ineffective treatment. Also, the state's revenue stream lags far behind skyrocketing health care costs.

The good news is the Legislature, acting in a rare bit of bipartisanship last session, has passed House Bill 3650, which seeks to cut down on needless red tape within the medical field and get patients preventive health care, as opposed to soaking them for pricey specialty procedures and then directing them into emergency rooms when crises arise, they said.

Sound too good to be true? Mike Bonetto, the governor's health policy adviser, doesn't think so.

"We are not trying to reinvent the wheel," Bonetto said. "But I'm not saying that we have everything all figured out."

Bonetto told the audience that the goal of HB 3650 is to get all areas of the medical field on the same page. The Oregon Health Authority believes that not having mental and physical health services interact and coordinate care is creating logjams in the system, which causes patients sometimes to see multiple doctors to get the same treatments repeatedly.

This is costing taxpayers millions and not keeping Oregon residents healthy, argued Dr. Barry Hamann, a family practitioner in Grants Pass.

"The current system incentivizes specialty care over primary care," Hamann said.

Hamann said he recently saw a patient who went to the emergency room once a month for the previous two years. The woman complained of a headache and received a CT scan several times in two years. Each of the scans came back negative, he said.

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"Does anyone know how much a CT scan costs?" he asked the crowd. "They are at least thousands of dollars each time."

Hamann said the woman suffered from a mental disability and needed psychiatric help, not more expensive tests that did nothing for her health.

Hamann, who said he is skeptical of government overreach in many cases, said the new law could help break down barriers between doctors and allow them to get care to patients quickly and at lower cost.

Tuesday's meeting was the second of eight stops throughout Oregon seeking input into how the law could benefit communities.

The crux of HB 3650 is the creation of Coordinated Care Organizations, which will group mental, physical and dental care providers together.

"This is only going to succeed if it works locally, for each community" said OHA spokeswoman Patty Wentz. "This isn't going to exist only in Salem."

Dr. Christian Mathisen, a Medford chiropractor, said he hopes the new law will include naturopaths, nutritionists and other alternative care providers.

OHA Director Bruce Goldberg said there is space in the new law for these care providers.

"We want to create alternatives to expensive care that doesn't work," Goldberg said.

Hamann said the law's success will hinge on whether doctors will realize the importance of affecting behavioral change on many patients. He said it is important to give doctors incentives for steering patients toward healthy eating and exercise.

"A big part of preventive care is lifestyle," he said.

If the federal government approves the provisions of HB 3065, the Coordinated Care Organizations could begin forming by July 2012.

Reach reporter Chris Conrad at 541-776-4471; or email [cconrad@mailtribune.com](mailto:cconrad@mailtribune.com).

# Statewide community meetings

## A new vision for the Oregon Health Plan

Under bipartisan legislation passed earlier this year, state lawmakers set a vision for local Coordinated Care Organizations (CCOs) with a goal of better health, better care and lower costs for the more than 600,000 child and adult Oregonians served by the Oregon Health Plan.

### Get involved!

The Oregon Health Policy Board and Oregon Health Authority invite you to learn more about Coordinated Care Organizations and local innovations that help point the way to better care at lower costs. Please bring your ideas about how CCOs could work best in your community.

Your input will be shared with the Oregon Health Policy Board members as they develop the final proposal for CCOs.

If you are unable to attend a meeting, you can find information and provide feedback at [www.health.oregon.gov](http://www.health.oregon.gov).

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- Roseburg:** **Monday, Sept. 26, 6-8 p.m.**  
Umpqua Community College  
Campus Center Building Dining Room  
1140 Umpqua College Road
  - Medford:** **Tuesday, Sept. 27, 6-8 p.m.**  
Santo Community Center  
701 N. Columbus Ave.
  - Pendleton:** **Monday, Oct. 3, 6-8 p.m.**  
Pendleton Arts Center  
214 N. Main St.
  - Florence:** **Wednesday, Oct. 5, 6-8 p.m.**  
The Florence Events Center  
715 Quince St.
  - Bend:** **Thursday, Oct. 6, 6-8 p.m.**  
The Riverhouse Convention Center  
2850 N.W. Rippling River Court
  - Portland:** **Monday, Oct. 10, 6-8 p.m.**  
University Place Hotel & Conference Center  
310 S.W. Lincoln St.
  - Eugene:** **Wednesday, Oct. 12, 6-8 p.m.**  
Campbell Senior Community Center  
155 High St.
  - Astoria:** **Thursday, Oct. 13, 6-8 p.m.**  
Clatsop Community College  
Columbia Hall, Room — Columbia 219  
1651 Lexington Ave.

## **1-Paragraph Summary of each of the September Transformation Workgroups**

### **9/20/11 Global Budget Methodology Work Group Meeting**

Global Budget Methodology Work Group members discussed their concerns about financial risk and ways to address those concerns. Carolyn Ingram, Senior Vice President at the health policy institute the Center for Health Care Strategies, presented examples of innovative Medicaid risk-sharing arrangements that other states have with their Medicaid plans. Work Group members pointed out that managed care organizations in Oregon have successfully handled all of the financial risk for their members, but CCOs may face challenges in taking on additional risk. Members also stressed that any risk-sharing arrangement with the state should last several years so that CCOs can make upfront investments to improve health care systems and then realize savings over time. Finally, work group members emphasized that outcomes should play a central role in risk-sharing arrangements. They felt that CCOs should demonstrate progress towards providing high quality coordinated care in order to share financial risk with the state.

Next Meeting: Monday, Oct. 17

Location: Cherry Tree Training Center, Salem, OR

### **9/21/11 CCO Criteria Work Group Meeting**

The CCO Criteria Work Group members discussed the most important aspects for the OHA to consider related to health equity as well as CCO governance and community engagement. This input is important to define CCO certification criteria, and ways that OHA might evaluate CCO strategic approaches and monitor success in meeting health systems transformation policy objectives. Regarding health equity, there was general agreement that the issue should be broadly framed, with race and ethnicity addressed in combination with such factors as age, gender and sexual orientation, income level, and rural/urban location. There was also agreement that while OHA might provide some state/regional level data, it would fall to the CCO to assess health disparities in its service area and to develop strategies for reducing these disparities based on that community assessment. It was also noted that substantial reduction in health disparities will depend on the representation of a region's diverse communities in the CCO's governance and community engagement processes. Transparency and accountability of governance were deemed crucial, as well as clearly defining the responsibilities and representation on the CCO boards and how that relates to risk sharing and financial relationships. In particular, accountability of the governing board to the community advisory council was identified as critical - including assurances that recommendations be fully considered, with feed-back on actions taken or deferred. Regarding values, it was noted that safeguards may be needed to assure that community values do not infringe upon appropriate access to health care covered through CCOs.

Next Meeting: Tuesday, Oct. 18

Location: Cherry Tree Training Center, Salem, OR

## **1-Paragraph Summary of each of the September Transformation Workgroups**

### **9/22/11 Medicaid/Medicare Integration Work Group Meeting**

The Medicaid/Medicare Integration Work Group members focused on metrics as they pertain to individuals that are dually eligible. Kay Metzger from Lane County AAA presented an orientation to the metrics by talking about the ADL (Activities of Daily Living) assessments that are currently being used by state and AAA case managers. Breakout groups focused on which domains of accountability are particularly relevant for individuals who are dually eligible; and how to best use metrics to hold systems accountable for transforming care and services to this population. The groups emphasized the importance of person-driven systems that include engagement, empowerment and personal accountability; measurements should have identified benchmarks or baselines; and metrics should reflect coordination between providers and CCOs across the spectrum of services, including long-term care. Workgroup members emphasized the significance of recognizing the diversity within the group of people who are dually eligible.

Next Meeting: Wednesday, Oct. 19

Location: Cherry Tree Training Center, Salem, OR

### **9/26/11 Outcomes, Quality, and Efficiency Work Group Meeting**

At their meeting on September 26<sup>th</sup>, members of the Outcomes, Quality, and Efficiency Metrics workgroup considered potential CCO performance measures in five topic areas: equity; coordination and integration; member (or patient) experience; access; and efficiency. Three workgroup members—Mylia Christensen (QCorp), Megan Haase (Mosaic Medical) and Vanetta Abdellatif—gave presentations about the using performance measures to help drive transformation. Workgroup members expressed support for establishing three kinds of CCO accountability metrics: uniform measures across all CCOs; CCO-specific measures; and test or developmental measures. They also stressed the importance of a robust HIT and EMR infrastructure for outcomes measurement. A subset of members voiced a preference for using outcome measures whenever possible, on the grounds that process measures would restrict innovation and limit CCO accountability.

Next Meeting: Monday, Oct. 17

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

## **CCO Criteria Work Group**

### **September 21, 2011 Meeting Summary**

#### **Discussion Topics**

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Oregon Health Policy Board member Eric Parsons gave a summary of the August meeting, including feedback from the Board and the public on the August discussions, and described the products that the Board will deliver to the Legislature in February. Co-Chairs Mike Bonetto and Bruce Goldberg framed the issue to be discussed (health equity, and CCO governance and community engagement) in terms of Health Systems Transformation policy objectives and the guidance in HB 3650. The group then divided into four discussion groups to consider the following discussion questions:

#### **Health Equity**

Health equity and reducing health disparities have been identified as a topic critical to the development of CCO criteria. Assume that the CCO criteria will require a solid approach to health equity and reducing health disparities, and that this approach will also be reflected in the CCO Business Plan.

1. How should we judge the response to that requirement?
2. What would you want to see as evidence that the potential CCO will/can address health disparities?
3. How should this be addressed in performance standards?

#### **Governance and Community Engagement**

1. What are the essential (given in the bill as requirements) and desired components of governance and community engagement that we believe will lead to success of CCOs in performing effectively for the communities they serve?
2. How can OHA evaluate the effectiveness of community engagement and CCO governance? In regions where there are more than one CCO, how should CCOs be compared in terms of effectiveness of community engagement and CCO governance?

#### **Key Points for the Oregon Health Policy Board**

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##### **Health Equity**

- Health disparities and resources for improving health equity need to be assessed on an ongoing basis, beginning with partnerships formed in the planning stages of the CCO certification process.
- Existing data sources (e.g., CAHPS, ER data, and county data) may be used as a starting point to assess health disparities, but the Medicaid and dually eligible populations may

not mirror total population data and CCO applicants should be required to develop and present their own assessment of their service area.

- Health disparities should be identified and addressed whether they are associated with race, ethnicity, age, disability status, mental health and addictions, gender and sexual orientation, or other factors. Race and ethnicity may indicate increased health disparities within some categories such as age and disability status.
- Health equity metrics should address both health outcomes and cost impacts.
- CCO governance and community engagement will be key elements in any successful approach to addressing health equity issues and reducing health disparities.
- CCOs need concrete goals and clearly defined working partnerships to address disparities, including social and support services. Periodic analysis (qualitative and quantitative) will be needed in evaluating effectiveness.
- Over time, CCOs should make substantial progress in addressing disparities relating to the social determinants of health.
- There should be a collaborative for identification and replication of best practices in addressing health equity issues and reducing health disparities.

### **Governance and Community Engagement**

- Safeguards are needed to ensure community values do not infringe upon rights to health care.
- Governance structures must be transparent and accountable, including clear delineation of holding companies and other affiliated organizations.
- The CCO certification process should make clear preferred or required corporate structures regarding such characteristics as for-profit/not-for-profit status, state of incorporation, and scope of operations (Oregon only, multi-state, national).
- The CCO governing board must make clear the fiduciary responsibilities of board members, including those not sharing in the financial risk.
- Community advisory councils must have teeth, with assurances that recommendations to the CCO governing board are fully considered and the community advisory committee is informed of actions taken or deferred.
- Governance and key staff of CCOs should reflect the roles and responsibilities typical of successful organizations in health care and health insurance, as well as the policy objectives of health systems transformation (such as health equity).
- A CCO clinical advisory council component should be considered as a means of assuring best clinical practices.
- OHA should consider an Ombudsperson for each CCO to assure effectiveness of the community advisory council and of community engagement in general.

- CCO governance and community engagement should be evaluated in terms of improvements in processes and outcomes.

## **Small Group Discussion**

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### ***Comments on Health Equity***

- **Defining health equity:** The way we define health equity is important. The group acknowledged the need for a broad and flexible definition that takes into account regional variation across the state. The group asked whether the state or CCOs should define health equity, and subsequent comments favored the state providing potential CCOs with information on health equity and a sample needs assessment framework that CCOs then use to develop their own definition of local disparities that need to be addressed, and their proposed approach to reducing disparities. How different CCOs carry this out will be indicative of their level of commitment to improving health equity. Group members pointed to recurring community benefit interviews as a necessary component of understanding local health disparities. Specific examples of areas that group members felt should be considered include: race, ethnicity, language, health literacy, people with disabilities, gender and sexual orientation, access issues in rural areas, and areas with high rates of uninsurance
- **Need minimum standards & flexibility:** CCOs will need to be held accountable for meeting certain minimum requirements in addressing health equity, but should maintain flexibility in the way they address disparities to reflect differences across communities.
- **Existing data sources** (e.g. CAHPS, ER data, claims data) can be a starting point in assessing health equity, but the Medicaid population will not mirror the general population, especially regarding characteristics relating to health disparities.
- **Local health disparities change over time:** Several group members emphasized that community demographics and health needs are always in flux and that needs assessments need to be performed on an ongoing basis. Recurring needs assessment and asset mapping should inform who serves on CCO governance and advisory boards. For example, Salud Medical Center has noticed a recent growth in the Somali community in Woodburn and is exploring ways to improve their access to care.
- **Social and human services should be coordinated with health services in addressing health disparities, and social justice factors should be included** (e.g., education, income, employment status).
- **The diversity of the CCOs providers should reflect the diversity of the communities in the CCO's service area.**

- CCOs can provide mutual support: Learning networks or collaboratives could help CCOs to share successes and lessons learned.
- Infrastructure for tracking outcomes: Many of the outcomes of interest cannot be tracked using existing claims database systems. This will require forethought in to how to track and report outcomes.
- CCO partnerships: CCOs will need to partner with local organizations in order to successfully understand and address health equity issue specific to the community. More specifically, CCOs should clearly specify their commitment to their partners and vice versa. Partnerships can help CCOs overcome a lack of financial resources to improve equity, but care must be taken so that CCOs do not try to offload their responsibility on to other organizations. The state could evaluate such relationships to determine CCOs effectiveness at improving health equity.
- CCOs' experience improving equity: Some group members felt that reviewing potential CCOs records in improving health equity (e.g., addressing transportation issues or language barriers) could be more indicative of their capacity to reduce disparities than would simply reviewing a prospective plan for improving equity.
- Granularity of data collected must be sufficient for racial and ethnic distinctions within broad classifications (e.g., within Asian - Chinese, Korean, Japanese, Vietnamese, Laotian, etc.; within Hispanic - Mexican, Guatemalan, Puerto Rican, etc.).
- CCOs should identify key community leaders who are appropriate representatives and work with those leaders to reach diverse communities with strategies for reducing health disparities.
- Addressing disparities through administrative processes: One member stressed the importance of administrative processes in reducing health disparities and suggested that the ways in which processes and forms (e.g., billing) were laid out could provide a clear indicator of CCOs work to improve health equity.
- CCOs need concrete goals: In their plans for addressing health disparities, CCOs should put forth specific, measurable and substantial but achievable goals for reducing health disparities, and define what investments they will make to reach these goals. Although change will take time, the state can assess CCOs progress against these goals. CCOs should describe both short-term and long-term goals. Because of the difference in the needs of varying groups, CCOs should likely stratify their population when setting goals. In addition, CCOs should be required to prioritize their goals.
- Additional potential evaluative criteria:
  - Staff training on health equity and disparities

- CCO workforce diversity
- CCO governance board and community advisory committee diversity

***Comments on CCO Governance and Community Engagement***

- Community values could conflict with reform: HB 3650 states that CCOs' governance structure includes "[t] the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community." Several members expressed concerns that some community values may conflict with the intent and policy objectives of health care transformation (e.g., addressing the health needs of immigrant communities or assuring appropriate end of life care services). That state should make its values clear, exercise existing safeguards when appropriate and develop new safeguards to the extent they are lacking. The state's certification process can communicate transformation values.
- Collaboration among community partners will be important in bringing resources together to leverage dollars and services. Asset assessment and mapping should be done for each CCOs service area.
- Governing board representation: some members expressed the importance that essential groups be represented on the governing board, including:
  - Individuals with financial risk for CCO performance
  - Physicians
  - Behavioral health providers
  - Consumers from all communities in the CCO service area
  - County governments
- Examples of other groups identified during the meeting included:
  - Dental health providers
  - Disability service providers
  - Social service providers
  - Long term care providers
  - Primary care providers
  - Hospitals
  - Foster care providers
- Role of corporate/parent company board in CCO governance: Group members discussed different possibilities for CCO governance in terms of its relationship with the governance board of its parent entity. Some members expressed concerns that the board of a parent company may not have well aligned interests with the governing board of a CCO. Some

members expressed an interest in having the state provide guidance or requirements on how CCO governance should be structured. Whatever the governance structure, it must be transparent and held accountable.

- Community advisory council “must have teeth”: Members agreed that the community advisory board must have influence in CCO governance. One mechanism to support this that was suggested was for community advisory boards to rate CCO governing boards on their effectiveness in assuring the health of the community.
- Process for selecting community advisory council members should be transparent and accountable: its success should be measured in terms of the effectiveness of the CAC in representing the needs and preferences of the communities in the CCO’s service area, in the form of policy recommendations and feed-back to the governing board on access and outcomes issues.
- The utilization and effectiveness of community health workers, health systems navigators, and peer wellness counselors should be evaluated in gauging the effectiveness of the Community Advisory Council.
- A clinical council should also be considered composed of providers of care and addressing issues relating to improving access and health outcomes, with significant input on the design and operation of the CCO delivery system.
- Traditional board roles should be required: Group members recommended that CCO boards should be held to commonly accepted organizational governance standards. For example, the CCO should have a chief compliance officer who reports directly to the CCO governing board.

## Global Budget Methodology Work Group September 20, 2011 Meeting Summary

### **Discussion Topic: Risk Sharing between State and CCOs**

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Carolyn Ingram—Senior Vice President at the Center for Health Care Strategies and former New Mexico State Medicaid Director as well as Senior Manager with the Lewin Group—presented examples of innovative Medicaid risk-sharing arrangements and discussed relevant considerations for evaluating them. Examples from other states included:

- Utah’s full-risk capitation arrangement that establishes rates for Accountable Care Organizations (ACOs) for five years; and,
- Minnesota’s shared risk (both upside and downside) arrangements with integrated delivery systems and shared savings (upside only) arrangements with other groups.

Key risk sharing considerations included:

- Incentives for greater efficiency and integration of care
- Fostering budget predictability
- Potential flexibility in setting up risk sharing arrangements
- Addressing administrative complexity

The work group split into three breakout groups to discuss their concerns with regard to financial risk, models that address those concerns, and incentives for promoting care coordination.

### **Key Member Feedback: Focus on Long-Term, Outcomes-Oriented Risk Arrangements**

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The small groups provided the following feedback

- Risk concerns
  - Actuarial models and soundness requirements need to be clearly defined
  - Existing MCOs are currently tapping reserves and may be poorly positioned to invest in transformation and take on additional risk.
  - Enrollment growth associated with the ACA poses an overall budgetary risk.
  - Savings from care coordination may take several years or more to realize.
  - If CCOs face too much risk, not only could members lose access, but entire health systems that are heavily dependent on Medicaid could erode.
- Model features and incentives that address concerns
  - Acknowledge what works with the existing system. Current MCOs have managed full risk and moving to partial risk arrangements may represent a step backwards. There is a need to identify key weaknesses in the current system, such as coordination between mental health and physical health, and to determine if new risk arrangements will address those concerns.
  - Pursue multi-year arrangements (e.g., five years). Investments in transformation will take time to pay off.

- Any risk sharing arrangement needs to promote outcomes in terms of care coordination, health and equity. Higher performing plans should receive more favorable risk arrangements.

Work group members requested more detail on changes that need to be made. They were very interested in understanding what the state believes is working in the current system in order to focus their planning and efforts on high-priority changes that need to be made.

## **Small Group Discussion**

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### **1. Risk Concerns Discussed**

#### Types of Risk – Actuarial, Performance and Transformation; Enrollment Risk from ACA

One breakout group categorized CCO financial risk as follows

- *Actuarial or Medical Risk* – Risk for claims driven by the health status of CCO members. This can be addressed by risk adjustment.
- *Performance Risk* – Risk of not being able to transform delivery systems to successfully provide coordinated care. CCOs should bear this risk, but the state should help to minimize it.
- *Transformation Risk* – The risk of not realizing sufficient savings to cover the budget shortfall even if transformation is successful. The state should acknowledge this risk and share it with CCOs.

Another group pointed out that enrollment risk can put pressure on the overall Medicaid budget. The planned expansion of Medicaid in 2014 will increase enrollment and significantly so in low-income communities. CCOs that serve these communities cannot handle this enrollment risk.

#### CCOs' Resources are Tight but Change is Inevitable

One group mentioned several financial strains on the Medicaid system from the state budget, to MCOs currently tapping reserves, to providers receiving lower rates. While this situation makes it difficult to assemble resources to carry out successful transformation (e.g., setting up robust information systems), but it also makes change inevitable.

#### Consumers Could Lose Access and Systems Could Erode if CCOs Face Too Much Risk

If CCOs become insolvent or reduce reimbursement to an unsustainable level not only could CCOs collapse, but also consumers could lose access to timely health care services and local health systems could split in terms providers who serve Medicaid members and those who do not or fall apart altogether. The latter is a more significant issue in communities where Medicaid coverage is prevalent.

### **2. Models that Address Concerns and Incentivize Transformation**

#### Building Off of Existing MCO Full-Risk Arrangements

Almost all of the current plans have full-risk arrangements, and we should build off of this capacity rather than curtail it.

#### Long-Term Risk Sharing Arrangements Are Preferable

Several groups emphasized that risk sharing arrangements with the state should have long time horizons. There was significant interest in the five-year contracts referenced in Carolyn Ingram's presentation. Successful transformation will take time and reaping the financial benefits of coordinated care will take even longer. Thus, risk sharing arrangements between the state and CCOs should allow enough time to invest in change and subsequently realize the return on this investment. Otherwise, CCOs will face lessened incentives to carry out transformation.

#### Focus on Outcomes

Each group made clear that any risk sharing arrangement between the state and CCOs must be structured to incentivize clinical integration, access, health outcomes and health equity. One group suggested that the initial focus should be on successful clinical integration and shift over time to health outcomes. This group also expressed that the state should take on a greater share of risk in proportion with CCOs' demonstrated successes in clinical integration (including physician driven quality improvement initiatives and provider shared risk/shared savings agreements). This would require the state to lay out more prescriptive measures and accountability mechanisms while still allowing CCOs to innovate.

Another group discussed the importance of financial arrangements pushing the integration of services as broadly as possible to support innovation and the "really hard work" of care coordination. Accountability systems will need to provide timely feedback and allow for adjustments over time.

#### Rate Setting and Risk Sharing Decisions Should Be Transparent and Involve CCOs

One group requested transparency with regards to actuarial modeling and soundness requirements as well as what changes are anticipated from transition. CCOs will need this in order to determine their ability to take on risk. Each group mentioned actuarial modeling and soundness in various contexts. Some wanted more information on its definition and the actuarial modeling that determines soundness. Others expressed concern that actuarial soundness's role in does more to promote insurers' interests but not the overall goals of the health care system. Finally, one group felt that CCOs need to be involved in the rate setting and risk sharing to make sure that they have bought in to the transformation process.

#### Removing Administrative Obstacles

Several groups stressed that removing administrative obstacles will be crucial to successful risk sharing. CCOs need flexibility to invest in effective services that are not currently covered without the state or federal government withdrawing risk sharing. The risk sharing arrangement itself should not create undue administrative burdens.

#### Spreading Risk

Although the focus of the meeting was risk sharing between the state and CCOs, several groups emphasized that upside and downside risk needed to be spread throughout the system—including the state, CCOs, providers and patients—in order to align incentives. However, several groups also noted that MCOs currently manage full risk through a capitation model, suggesting that we could build off of this and that moving to a partial risk arrangement with the state could represent a step back.

#### Flexible Risk Arrangements to Address Community Differences and Change Over Time

Several groups mentioned that there may be a need for different models of risk sharing arrangements in different communities. Different communities have different underlying needs and have experienced different degrees of success in achieving good health outcomes under the current system. In addition, CCOs capacity to manage risk should increase with experience. As a result, risk arrangements should allow for CCOs exposure to financial risk to change over time.

#### ***Additional thoughts that emerged from workgroup discussions***

- Coordination with social services can improve outcomes: One group emphasized the need to improve the connection between the health system and social services, asking if CCOs should bear risk for social services as well.
- The state could provide technical assistance to implement provider payment reform.

## **Outcomes, Quality, & Efficiency Metrics Work Group**

### **September 26, 2011 Meeting Summary**

#### **Discussion Topics**

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Oregon Health Policy Board member Dr. Carlos Crespo gave a re-cap of the August meeting, summarized feedback from the Board and the public on the August discussions, and described the products that the Health Policy Board will deliver to the Legislature in February. Workgroup members also heard three brief presentations on the topic of using performance measures to help drive transformation. The group subsequently was divided into three smaller discussion groups to consider potential CCO performance measures in five topic areas: equity; coordination and integration; member (or patient) experience; access; and efficiency. Members were asked to address three questions in relation to the example measures listed (*see meeting materials*):

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

#### **Key Points for the Oregon Health Policy Board**

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- Members expressed support for the three ‘buckets’ of measures outlined by Dr. Hofmann and the Health Policy Board: uniform measures across all CCOs; CCO-specific measures; and test or developmental measures.
- At both the August meeting and this one, workgroup members expressed an interest in keeping all types of measures—structure, process, and outcome—on the table, as long as the measure type was appropriate to the topic. However, at the September meeting, several people expressed a strong preference for using outcome measures whenever possible, on the grounds that process measures would restrict innovation and limit CCO accountability (the more the state dictates the process, the more the state itself becomes accountable for the result). One suggestion was to use process measures when there are key evidence-based practices we know we want to promote and when outcomes are difficult to measure or have a long time-frame for measurement.
- Members stressed the importance of EMR and HIT capacity for both CCO operations and the ability to capture the kind of outcomes data that the group is interested in for performance measures. However, some members cautioned that claims data will still be valuable even when EMRs are widely used, and others reminded the group that neither data source will capture the health of CCO members who aren’t using services.
- In some small workgroups, questions arose about the scope of CCO accountability. There remains some confusion about the extent to which CCOs should be responsible for the

health of people who are not CCO members, but who reside in the communities that a CCO serves.

- At various points, members noted that transformation would also be required within the state to support delivery system transformation.

## **Presentations**

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Workgroup members heard three brief presentations on the topic of using performance measures to help drive transformation.

- Mylia Christensen—workgroup member and Executive Director of the Oregon Healthcare Quality Corporation—gave an overview of the state of quality measurement around the transformation-related topics on the meeting agenda. She noted that measurement of these topics was a rapidly developing field and that there is no performance data from entities comparable to CCOs from which to develop benchmarks. As a consequence, the principles and criteria discussed at the last meeting become very important. She urged the group to focus on things CCOs can change, choose valid measures that harmonize with other initiatives where possible, and to think carefully about granularity and level of measurement.
- Megan Haase—CEO of Mosaic Medical in Bend—described a care coordination pilot for high utilizers and distributed a list of the quality measures used in association with the shared savings component of that pilot (*see meeting materials*). She noted that some of the initially selected metrics did not work well and needed to be replaced for year 2 of the pilot and that they were working to get claims data in a more timely manner while waiting for EMR capacity to mature.
- Vanetta Abdellatif—Director of Integrated Clinical Services at the Multnomah County Health Department—provided an overview of a medical home pilot project at Multnomah County (*see meeting materials*). She noted some impressive results in improved clinical outcomes (e.g. diabetes bundle, severe depression), continuity rates, and patient-centeredness. She urged the group not to let perfection be the enemy of good enough.

## **Small Group Discussion**

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

### *General Comments*

- Several members commented that behavioral health issues (both mental health and addictions) were not visible enough in the list of measures proposed for discussion.
- Similarly, members were interested in seeing more potential indicators of overall health outcomes and around CCOs' level of community engagement. With respect to community

engagement, one breakout group suggested monitoring CCOs' success in reaching out to and engaging all of its members, or awarding 'bonus points' for CCOs that use innovative methods (such as use of Community Health Workers) for outreach, leading to better patient engagement.

- One member urged the group to think about performance measures that would be meaningful to individuals making a choice between CCOs.
- Another suggested that OHA should determine the cost of measurement and reporting for the final set of CCO accountability measures selected and critically examine the value.
- Finally, one member commented that performance measures will not be a sufficient to judge CCO performance and transformation; formative evaluations (audits) will also be needed.

#### *Comments on potential measures of Equity*

- There was some debate about whether equity should be called out as a separate topic for CCO accountability, with its own performance measures, or whether attention to equity should be infused throughout the other topics. The danger in the first approach is that equity concerns become compartmentalized; the danger in the second is that they get lost. The loose consensus in one breakout group was that a combined approach would be best, with some commenting that it might be possible to retire a separate equity set of measures after some period of CCO operation.
- Several members advised OHA to consider factors like disability status, LGBT identification, or presence of a mental illness when monitoring CCO's success in improving health equity, along with race, ethnicity, and primary language.
- One member commented that OHA needs to take more responsibility for improving the quality of race, ethnicity, and primary language data collected at eligibility/enrollment. In another group, members suggested that CCOs ask directly about the language in which members prefer to receive services and information, as a component of addressing health literacy.
- One member suggested that the Office of Multicultural Health should help decide on equity metrics.
- Additional Equity measures suggested include (these are also listed in the table following this section):
  - A structural measure of CCO workforce composition
  - A measure of CCOs' success in reaching out to members who do not utilize services

#### *Comments on potential measures of Care Coordination and Integration*

- Measures under this topic should align with those used for the children's wraparound initiative (HB 2144) and the Governor's Early Learning Council (e.g. Kindergarten Readiness).

- Additional Coordination and Integration measures that were suggested include (these are also listed in the table following this section):
  - Coordination with community-level resources (e.g. percentage of medical teams that have coordination with community teams for community services and supports)
  - Coordination of care at the end of life

*Comments on potential measures of Member (Patient) Experience and Engagement*

- One group commented that member/patient experience may be the single most important aspect of CCO performance to measure.
- However, the same group cautioned that member surveys are expensive to support over time and suggested that consolidated survey efforts and/or standard instruments would be more practical and valuable than multiple levels of survey administration or multiple versions of questionnaires.
- In full group discussion, it was noted that expense of member experience surveys is driven by how much granularity is desired in the results (CCO-wide? Medical group level? Individual clinician?). Another member commented that the data become less actionable as granularity decreases and gave the CAHPS Health Plan survey as an example of a survey that does not generate useable information.
- Measurement of experience should go beyond satisfaction to assess whether members' informational needs are being met and the quality of members' relationships with their providers.
- Some workgroup members saw increasing member activation as key to the CCO concept; others felt that activation would not be a valuable CCO performance measure because activation is only an intermediate step to an ultimate goal (e.g. better patient self-management).
- Additional Patient or Member Experience measures suggested include (these are also listed in the table following this section):
  - Some measure of churn, either from CCO to CCO or from provider/group to provider/group within a CCO

*Comments on potential measures of Access*

- There was some debate about the merits of using patient- or member-reported data vs. objective data on utilization rates or penetration to assess access. Some members consider member reports less valuable because patients sometimes feel that they need more care than they do; others believe that this is an important gauge of patient experience. A balance between the two data types would be best.
- Additional Access measures that were suggested include (these are also listed in the table following this section):

- Utilization of preventive and primary care service utilization specifically
- (Appropriate) emergency department utilization (listed under Efficiency)
- Penetration/take-up of addiction services

*Comments on potential measures of Efficiency and Costs*

- Members commented that risk adjustment would be necessary to compare across CCOs and across providers within CCOs. They suggested that individuals eligible for both Medicare and Medicaid would be a particular challenge for risk adjustment.
- Members stressed the need to measure access and quality of care (according to evidence-based guidelines) alongside efficiency and costs, to guard against unintended consequences or perverse incentives for inadequate care.
- Members made a few suggestions for analytic approaches to efficiency and cost control that may be most appropriately undertaken by CCOs themselves, including:
  - Monitoring spend on “high-risk” groups as a proportion of total costs;
  - Assessing cost drivers within the CCO population and making shifts in services or reimbursement rates accordingly.
- More than one group emphasized the importance of measures that would assess whether the most appropriate and efficient mix of services is being delivered to members (e.g. ED visits vs. office visits, or ED visits for dental, mental health, or substance abuse issues).
- Additional Efficiency or Cost measures that were suggested include (these are also listed in the table following this section):
  - Some measure(s) of cost shift:
    - To services and facilities outside the CCO umbrella and budget (e.g. state hospital)
    - Towards prevention and primary care within the CCO budget (over time, utilization and proportion of spend in these areas should increase)
  - Cost trend over time (e.g. average annual change in per-capita expenditure)
  - Medical Benefit Ratio (MBR or MLR) - Proportion of revenue/global budget spent on medical care and services
  - Some measure of costs or appropriate utilization of care at the end of life (e.g. % members for whom end of life care matches POLST; or % members who die in the hospital; or hospice LOS; or use of palliative care)

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

Measure	Data type	Alignment *	COMMENTS
<b>Topic: Equity</b>			
<p>Note: It is assumed that CCOs will be subject to the new OHA &amp; DHS policy regarding collection of race, ethnicity, and primary language data, such that any CCO performance measure could be reported and analyzed by those demographic factors (numbers permitting). For contractual accountability, we are considering focused measures such as the ones below.</p>			
<p><b>Cultural competency</b> - composite score for provider cultural competency from CAHPS supplemental item set</p>	Patient or enrollee survey	AHRQ (CAHPS)	<ul style="list-style-type: none"> <li>· Fold this into patient experience</li> <li>· This item set is relatively untested</li> <li>· Culturally competent care is particularly critical for high needs patients</li> </ul>
<p><b>Diversity training</b> % CCO staff (clinical and administrative) who have received diversity training</p>	Admin data	JCAHO, NQF	<ul style="list-style-type: none"> <li>· This should be a contractual requirement, if used</li> <li>· This does not necessarily differentiate between CCOs in a useful way</li> </ul>
<p><b>Variations in care</b> Variation by race, ethnicity, and primary language on these measures:</p> <p><b>Access</b> - average time from enrollment to first encounter AND nature of first encounter (initial health &amp; risk assessment, other non-urgent, or urgent)</p> <p><b>Chronic disease management</b> - % diabetics with dilated eye exam in last year</p> <p><b>Care coordination</b> - % enrollees discharged from hospital who have a visit with PCP within 30 days</p> <p><b>Provider communication</b> – composite score for quality of provider communication (patient reported data)</p>	<p>Claims / encounter data</p> <p>Claims / encounter data</p> <p>Claims / encounter data</p> <p>Patient or enrollee survey</p>	<p>Unknown</p> <p>Medicare ACOs, Meaningful Use, QCorp</p> <p>Medicare ACOs</p> <p>CAHPS Medicaid adult; CHIPRA, HEDIS</p>	<ul style="list-style-type: none"> <li>· This isn't or needn't only be about equity; it's simply unwarranted variations in care more broadly</li> <li>· Don't specify an arbitrary focus a priori; instead see what variations emerge from the data</li> <li>· Dilated eye exam in particular is not compelling; patient experience, readmissions, and others likely better</li> </ul>

Measure	Data type	Alignment *	COMMENTS
<b>Workforce composition (structural measure)</b>			· Availability of interpretive services also mentioned but perhaps as a contractual requirement
<b>Measure of capacity or success of outreach to enrollee population</b> (could be specifically the portion of members not utilizing care)			
<b>Topic: Coordination &amp; Integration</b>			
<b>Patient-centered medical homes</b> % enrollees assigned to a PCMH	Admin data	OR PCPCH	
<b>Follow-up after hospitalization</b> % enrollees discharged from hospital who have a visit with PCP within 30 days  % enrollees discharged with a primary mental health diagnosis who have a follow-up visit within a) 7 days and b) 30 days	Claims / encounter data  Claims / encounter data	Medicare ACOs  Medicaid adult, CHIPRA, HEDIS	· 30 days is too long (use 7-10 instead, according to member risk) and don't just count follow-up visits to PCP.
<b>Care Transition Measure (CTM-3)</b> 3-item questionnaire measuring quality of patient preparation for transitions (understanding own role; medication reconciliation; incorporation of personal preferences into care plan)	Patient survey – hospital setting	Medicare ACOs	· Prefer to measure outcome (e.g. readmissions)
<b>Medication reconciliation ^</b> % of discharges for patients aged 65+ where medications were reconciled on or within 30 days of discharge.	Claims / encounter data or medical record	Medicare ACOs, HEDIS	· This too should be within 7-10 days, not 30 · Why limit this to 65+ when it is relevant for everyone? · “Reconciliation” is a difficult term to operationalize; call this coordinated medication management plan.

Measure	Data type	Alignment *	COMMENTS
<p><b>Behavioral health integration ^</b></p> <p>% members with a chronic disease diagnosis who received screening for depression and substance abuse in past year</p> <p>% members with a mental health or substance abuse diagnosis who received physical health screening in past year</p>	<p>Claims / encounter data or medical record</p>	<p>Partial: Medicaid adult, Medicare ACOs, OR PCPCH</p>	<ul style="list-style-type: none"> <li>· EVERYONE should receive these screenings but keep this focus for performance measurement as it will help push transformation</li> <li>· One member commented that appropriate follow-up should be part of these measures, as opposed to screening alone</li> </ul>
<p><b>Readmission rates ^</b></p> <p>Plan (CCO) risk-adjusted, all-cause 30-day readmission rate (NCQA/HEDIS measure)</p> <p>Inpatient psychiatric care: 30- and 180- day readmission rates</p>	<p>Claims / encounter data</p> <p>Claims / encounter data</p>	<p>Medicaid adult, HEDIS, Medicare ACOs</p> <p>SAMHSA - National Outcome Measure</p>	<ul style="list-style-type: none"> <li>· Several members emphasized the usefulness of monitoring readmissions as an outcome measure for care coordination and successful transitions of care</li> <li>· Readmissions are also relevant to costs/efficiency</li> </ul>
<p><b>Coordination with child welfare</b></p> <p>% children who receive a mental health assessment within 60 days of being taken in to DHS custody</p>	<p>Claims/ encounter data with child welfare data</p>	<p>Federal regulation; CAF and AMH initiative</p>	<ul style="list-style-type: none"> <li>· Goal is good but this is largely outside CCO sphere of influence – do not use.</li> <li>· Suggestion to measure the number of foster placement disruptions due to mental or behavioral issues instead</li> </ul>
<p><b>Children’s oral health screening</b></p> <p>% of children under 36 months who have received oral health risk assessment (from dental professional or as part of regular well-child visit)</p>	<p>Claims / encounter data</p>	<p>Pending</p>	<ul style="list-style-type: none"> <li>· Wherever possible, don’t just measure screening – it’s the follow-up that is important (e.g. application of fluoride varnish in this case)</li> <li>·</li> </ul>
<p><b>Coordination with Community</b></p> <p>E.g. % of medical teams with that coordinate with community-level resources</p>			<ul style="list-style-type: none"> <li>· Would need encounter for community services and supports</li> </ul>

Measure	Data type	Alignment *	COMMENTS
<b>Care coordination at the end of life</b>			
<b>Topic: Patient Experience and Engagement</b>			
<p><b>Patient experience of care</b></p> <p>From CAHPS Health Plans &amp; Systems survey (adults &amp; children sampled separately, includes items for children with chronic conditions) :</p> <ul style="list-style-type: none"> <li>· Provider communication composite</li> <li>· Customer service composite (treated with courtesy &amp; respect)</li> <li>· Overall rating of primary provider</li> <li>· Overall rating of quality of health care received</li> </ul> <p>From annual survey of mental health service recipients:</p> <ul style="list-style-type: none"> <li>· % reporting that the services they received were appropriate and good quality</li> <li>· % caregivers reporting satisfaction with coordination between mental health provider and other social services (education, law enforcement, etc.)</li> </ul>	Patient or enrollee survey	Medicaid adult; CHIPRA, HEDIS (Medicare ACO reporting includes items from the CAHPS clinician & group survey, not the Health Plan version)	
<p><b>Shared decision-making ^</b></p> <p>% respondents reporting that, when multiple treatment options were available, their provider: a) explained the pros &amp; cons; and b) asked what option would work best for respondent</p>	Patient or enrollee survey	HEDIS (these items are from NCQA's version of CAHPS)	<ul style="list-style-type: none"> <li>· <a href="#">This is part of quality of patient-provider relationship</a></li> <li>·</li> </ul>

Measure	Data type	Alignment *	COMMENTS
<p><b>Patient Activation Measure (PAM) ^</b> 13-item scale developed by Judy Hibbard; measures knowledge, skills and confidence essential to managing one’s own health and healthcare</p>	Patient or enrollee survey	Unknown	<ul style="list-style-type: none"> <li>· Is this appropriate for CCO-level accountability or action?                             <ul style="list-style-type: none"> <li>· Perhaps this is something CCOs could offer as a tool to providers?</li> <li>· Or phase it in? E.g. initial accountability could be that CCOs assess patient/member activation and longer-term accountability could be to improve member activation over time?</li> </ul> </li> </ul>
<p><b>Member churn</b> From provider to provider within CCO, and across CCOs</p>			<ul style="list-style-type: none"> <li>· May not always be related to member experience; could be convenience or some other factor unrelated to their experience of care</li> </ul>
<b>Topic: ACCESS</b>			
<p><b>Getting needed care ^</b> % enrollees reporting that it was usually or always easy to get appointments with specialists and get the care, tests or treatment they needed (composite from CAHPS Health Plans &amp; Systems)</p>	Patient or enrollee survey	Medicaid adult	
<p><b>Getting care quickly ^</b> % enrollees reporting that it was usually or always easy to get care as soon as they needed (composite from CAHPS Health Plans &amp; Systems)</p>	Patient or enrollee survey	Medicaid adult	
<p><b>Time to care</b> Average time from enrollment to first encounter AND nature of first encounter (initial health &amp; risk assessment, other non-urgent, or urgent)</p>	Claims / encounter data	Unknown	
<p><b>Preventive dental services</b> % enrollees who received a preventive dental service during measurement year (by age)</p>	Claims / encounter data	CHIPRA, OR PCPCH	

Measure	Data type	Alignment *	COMMENTS
<b>Mental health service penetration</b> % enrollees who utilize mental health services	Claims / encounter data	AMH	<ul style="list-style-type: none"> <li>· Worth highlighting given importance of mental health issues but would need to have decent estimate of underlying need first, at CCO level</li> <li>· Call out addictions as well</li> </ul>
<b>Preventive services</b> % enrollees who access primary care and preventive services			
<b>ED utilization</b> Note: This was suggested under Access by one group; it was also listed under Efficiency in the original discussion document)			
<b>Topic: EFFICIENCY and COSTS</b>			
<b>Hospital utilization</b> Admissions per member-month	Claims / encounter data		<ul style="list-style-type: none"> <li>· Prefer to measure ambulatory-care sensitive admissions (e.g. AHRQ measures)</li> </ul>
<b>Average hospital length of stay</b>	Claims / encounter data		
<b>ED utilization</b> ED visits per member-month	Claims / encounter data		<ul style="list-style-type: none"> <li>· Prefer to measure non-emergent ED visits (e.g. using NYU algorithm)</li> </ul>
<b>PMPM costs for:</b> Emergency Department Inpatient Hospital Outpatient Hospital Ambulatory Surgical Center Professional Services Drugs	Claims / encounter data		<ul style="list-style-type: none"> <li>· In one group, members advised not using these as performance measures. They argued that each CCO will have its own contracts, so the information would not be meaningful. Similarly, CCOs could decide to put money towards care not captured in these categories (e.g. alternative medicine).</li> <li>· Another group suggested that mental health and oral</li> </ul>

Measure	Data type	Alignment *	COMMENTS
Durable Medical Equipment Imaging Services Laboratory			health should also be tracked specifically, along with total PMPM as well.
<b>Use of imaging studies for low back pain ^</b> % of members with a primary diagnosis of low back pain who had an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis	Claims / encounter data or medical record	Medicaid adult, Meaningful use, OR PCPCH, HEDIS, QCorp	· One group had some disagreement about the value of this particular measure. There is national and state momentum around reducing inappropriate imaging but some felt that costs of imaging were too varied.
<b>Cesarean rate ^</b> % of women with first, live, singleton birth (not breach) who had cesarean	Medical record or birth certificate	CHIPRA	· Need to consider population risk with respect to this measure. Elective cesareans for full-term, healthy births is a more obviously “negative” measure.
<b>Cost trend measure</b> (e.g. average annual change in per-capita expenditure)			
<b>Medical benefit ratio ( or medical loss)</b> Proportion of premium revenue (or global budget) spent on medical care and services			
<b>End of life measure (re: cost)</b> Some measure(s) of appropriate resource use at the end of life			<ul style="list-style-type: none"> <li>· % members for whom end of life care matches POLST</li> <li>· % members who die in the hospital</li> <li>· Hospice LOS</li> <li>· Use of palliative care</li> </ul>
<b>Some measure of cost shift to services and facilities not under the CCO umbrella</b>			

## **Medicare – Medicaid Integration of Care and Services Work Group September 22, 2011 Meeting Summary**

### **Discussion Topics**

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#### **Letter of Intent to CMS**

Co-Chair Judy Mohr Peterson presented the group with a draft letter of intent to pursue a memorandum of understanding with the Centers for Medicare and Medicaid Services (CMS) in response to a State Medicaid Directors letter. The purpose of this letter was to inform CMS that Oregon is proposing to adopt a statewide capitated model for integrating and coordinating health care delivery system to better serve individuals who are dually eligible for Medicare and Medicaid. Discussion included questions about CMS financial participation in a new model, and around the vision for shared financial responsibility between Coordinated Care Organizations (CCOs), the state, and providers of long term care supports and services.

#### **Orientation to ADLs, Metrics and Our Current System**

Kay Metzger of Lane County Area on Aging Agency (AAA) and Bob Weir, Field Operations Manager for the Northwest Senior and Disability Services provided the group with an orientation to long-term care case management focused on metrics. They handed out the Activity of Daily Living (ADL) Assessment Tool, Service Assessment Basics, and an example of a “Day in the Life” of a case manager, demonstrating the complexity and coordination/integration currently experienced by Seniors and People with Disabilities (SPD) / AAA case managers.

#### **Breakout Groups**

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

- What domains of accountability are particularly relevant for individuals who are dually eligible?
- How do we use metrics to hold systems accountable for transforming care and services to individuals who are dually eligible?

#### **Key Points for Oregon Health Policy Board – Proposed CCO Accountability Metrics and Domains**

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The following were the key points that the workgroup members wished to present to the Health Policy Board.

Accountability domains should reflect the following:

- Person driven systems should include empowerment, engagement as well as individual accountability
- Long term care system performance
- Lowering cost through more appropriate utilization
- Improving quality of care
- Expanding use of non-traditional work force

Accountability metrics should reflect the following:

- Clear benchmarks or baselines across CCOs
- Understanding within metrics development that the population of individuals receiving both Medicare and Medicaid is diverse and have unique needs
- Metrics should reflect coordination between providers and CCOs
- Mental health measures
- Measuring patient engagement as well as involvement of “natural advocates”
- Qualitative measures should be integrated
- Measuring all performance, including poor performance

### **Small Group Discussion**

#### ***What domains of accountability are particularly relevant for individuals who are dually eligible?***

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Members reflected on the Proposed Principles and Domains of Accountability document that was presented to the Health Policy Board from the Outcomes, Quality, and Efficiency Metrics workgroup.

The breakout groups supported the following as important domains from the Domains of Accountability document to include when considering individuals who are dually eligible:

- Care coordination
- Access
- Cost containment, including through more appropriate utilization
- Patient activation

The suggested additional stand-alone domains to include were:

- Workforce capacity and development, including the non-traditional workforce
- Patient centeredness or patient driven care
- Patient empowerment and engagement
- Quality of care
- Safety/avoiding harm
- Patient responsibility/accountability
- Long term care system performance

Groups recommended that the coordination of care should include coordination between the CCO and the Long Term Services and Supports system; as well as coordination of care between providers within the CCO.

All of the breakout groups endorsed need for a core set of system performance and transformation domains with associated benchmarks to

- Ensure comparability of CCOs
- Track performance
- Conduct research and identify trends over time

Other discussion points included:

The proposed domains may not necessarily reflect the needs of key sub-populations or populations of focus, such as individuals with severe mental illness or individuals with dementia.

Additionally, some workgroup members felt that organizing system performance by service type/provider could have the potential for reinforcing silos rather than breaking them down. For example, in an integrated delivery setting, measuring mental health care separately from prevention or outpatient care would not be as relevant as measuring the effect of care on the whole person.

The prevention domain should include the concept of maintaining highest level of function.

***How do we use metrics to hold systems accountable for transforming care and services to individuals who are dually eligible?***

Members reflected on the handout outlining four proposed areas for metrics, including: Healthy Days, Improvement in ADLs, End of Life Care, and Innovation measurements.

Members generally endorsed the proposed metric provided. Metrics that were associated with broader health outcomes, (e.g. healthy days measure or number of days spent in home or home like environment) were thought to be more transformative, as good scores on these metrics would require that a range of medical, social and care coordination activities would have had to happen.

Metrics related to patient experience and involvement:

- Patient-centeredness, although not necessarily easy to measure, would be important
- Patient engagement including involvement of “natural advocates”
- Metrics that track the health of family or caregivers (or their level of strain) were thought by some to be as important as metrics associated with beneficiary outcomes
- Social engagement of beneficiaries (e.g. degree of isolation or objective measure of social network) beyond the medical services network
- Social determinants of health, such as profound isolation, are associated with poorer overall health and poorer responses to treatment; need to include in metrics but challenging to measure
- Patient experience or care or patient satisfaction data might be collected by trained peer specialists, or health system navigators

Metrics related to care:

- Early intervention and prevention are important to prioritize and align system incentives to emphasize
- Mental health measures
- Prevention should include maintaining activities of daily living

Metrics related to functionality:

- Measures of functionality should reflect the improvements possible in the beneficiary. For example, some beneficiaries will demonstrate improvement in ADLs and self sufficiency functioning while some beneficiaries will demonstrate maintenance or “highest level of functioning possible”
- Need broader measures of functionality beyond ADLs – SAMHSA’s self-sufficiency matrix was suggested as a resource/model

Additional comments on holding CCOs accountable through metrics:

- Need to establish ahead of time, clear benchmarks or baselines across CCOs
- Understanding within metrics development that the population of individuals receiving both Medicare and Medicaid is diverse and have unique needs
- Metrics should reflect coordination between providers and CCOs
- Qualitative measures should be integrated
- Measuring all performance, including poor performance

## **Coordinated Care Organizations**

Coordinated Care Organizations (CCOs) are primary agents of the health system transformation envisioned in HB 3650. Here is information about what CCOs are and the responsibilities they will have in supporting health system transformation in Oregon. The final approval for the plan for CCOs will go to the legislature in February, 2012.

### **Organizational Structure**

The organizational structure is not dictated through HB 3650, so that each local community would have the flexibility to design the CCO that best meets their needs. They may be local, community-based organizations or statewide organizations with community-based participation in governance; they may be single corporate structures or networks of providers organized through contractual relationships. While there would not be a specific designation of the number of CCOs or the number of services areas, each CCO must have the size and the organizational capacity to manage risk and assure appropriate access to integrated care and improved health outcomes. CCOs would be charged with developing a comprehensive service delivery network with patient-centered primary care homes at the core. The network should include a demographically diverse, culturally competent set of providers with linkages to community and social support services and partnerships with state and local governments. It is understood that current managed care organizations may shift operations to position themselves as CCOs.

Recent discussions have explored the possibility of a three-way contractual relationship between CCOs, the State of Oregon, and the Federal government to provide care to individuals who are dually eligible for Medicare and Medicaid. CCOs may also be required to submit business plans that identify specific organizational structures.

### **How care for OHP members would be different from today**

The introduction of CCOs is expected to reduce fragmentation of care for OHP members with a goal of patient-centered care. CCOs would take a holistic approach to care that includes developing individual treatment plans with member and family/caregiver participation, while prioritizing working with high risk members and those with chronic health care needs to reduce avoidable emergency room use and hospital admissions. Members should receive assistance in navigating the health care delivery system and accessing community and social support services from appropriate personnel such as certified health care interpreters, community health workers and personal health navigators.

As enhanced care coordination will likely result in utilization shifts among different provider types, CCOs may be required to provide details on how services will be provided to match member needs. CCOs may also be responsible for developing protocols addressing hospital discharge and other transition planning with members.

### **How CCOs would encourage optimal health outcomes**

CCOs would be encouraged to use alternative payment methodologies that would result in a shift from incentives for treating illness to incentives for optimal outcomes, fostering shared responsibility. CCOs would have the flexibility to choose the methods that work best for them. Going forward, however, OHA plans to offer a range of preferred methodologies in order to promote standardization and alignment with other payers. Preferred models may include payments for episodes of care and incentives for quality.

### **How CCOs would be held accountable to the community**

As specified in HB 3650, each CCO would be governed by a board with representation from its respective provider types and community partners. CCOs must also convene a community advisory council that includes communities, local government, and consumers to ensure the health care needs and preferences of consumers and the community are addressed. External workgroups convened by the Oregon Health Authority (OHA) have emphasized that governing boards and community advisory councils must collaborate to be effective.

CCOs would be held accountable for their performance via outcomes, quality, and efficiency measures currently being identified with the help of an external stakeholder workgroup. CCOs may also be required to describe their plans for establishing a quality improvement committee, a quality strategy, and a utilization management process.

### **How CCOs would be financed**

HB 3650 calls for a global budgeting process for determining payments to CCOs that may include risk adjustment mechanisms as well as risk sharing arrangements between CCOs and the state. CCOs would be required to demonstrate that adequate provisions are in place to protect members and providers in case of insolvency, which may entail a financial solvency plan based on enrollment expectations. External workgroup members have argued that CCO global budgets should focus on long-term, outcomes-oriented risk arrangements with transparent actuarial models.

### **How CCOs would be different from existing health plans**

CCOs would have a broader array of functions and responsibilities than current health plans and will have greater flexibility to carry out their work. In addition to providing integrated physical, oral, mental health and chemical dependency services, CCOs will be accountable for managing care in a way that helps to reduce medical cost inflation and ensure quality, affordable health care for Oregonians. As suggested in HB 3650, this will entail new systems of governance, greater attention to health equity, strong patient and community engagement, and use of new delivery models like patient-centered primary care homes (PCPCHs). A new global budget methodology and outcomes-focused accountability criteria will give CCOs the means and incentive to achieve the goals of transformation.

### **How CCOs would focus on health promotion and prevention**

CCOs would be expected to provide evidence-based care in a manner that supports prevention, contains costs, and improves health outcomes and quality of life for members. This may include conducting health risk assessments and contributing to public health and health promotion planning efforts.

### **How CCOs would reduce/control administrative costs**

All CCOs would be required to participate in administrative simplification by utilizing claims and encounter data standards, increasing electronic payment capabilities, and streamlining the prior authorization process for health care services. CCOs are also required by HB 3650 to utilize a universal credentialing process.

### **How CCOs would use Health Information Technology (HIT) to improve health care**

HIT infrastructure is integral to population health management and the provision of coordinated care. There may be contractual requirements related to technical systems and staffing capacity to ensure that CCOs and their providers can use patient-level data to coordinate care and drive improvements in health care delivery and payment.

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

This document reflects ongoing OHA/DHS staff analysis of issues relating to the statement of work and certification criteria for Coordinated Care Organizations (CCOs) that will contract with OHA under HB 3650. It will be revised and expanded over the next several months to reflect discussion and input from the External Work Groups appointed by the governor, feedback from other stakeholders, discussion and recommendations from the Oregon Health Policy Board, and guidance from the 2012 Legislative Session. **This is a working document and is for discussion purposes only.**

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<b>Each member receives integrated person-centered care and services designed to provide choice, independence and dignity</b>	AWAITING SPECIFIC details from discussion at the Medicaid and Medicare Integration Work Group and policy guidance from the OHPB	AWAITING SPECIFIC details from discussion at the Medicaid and Medicare Integration Work Group and policy guidance from the OHPB	<ul style="list-style-type: none"> <li>• Patient experience of care data (e.g. CAHPS measures)</li> <li>• Shared decision making measures</li> </ul>	
<b>Health care services...focus on...improving health equity and reducing health disparities</b>  Ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors.	CCO demonstrates an understanding of the diverse communities and health disparities in its service area (e.g. via a needs assessment) and describes an approach to substantially reducing these health equities over time.	CCO demonstrates meaningful and systematic engagement with critical populations in its community to create and implement plans for addressing health equity and health disparities.	<ul style="list-style-type: none"> <li>• Community needs assessment results</li> <li>• A comprehensive community oriented health equity plan.</li> </ul>	
	CCO demonstrates how it will address disparities in the delivery of health care services and in health outcomes (access to care, quality of care, chronic	CCO develops long term plans that incorporate innovation over time to substantially reduce disparities relating to the social determinants of health, including race and ethnicity in combination with age, income, gender,	<ul style="list-style-type: none"> <li>• Reduction of unwarranted variations in care and outcomes by race, ethnicity, primary language and other factors.</li> </ul>	

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
	disease management, care coordination, provider communication, etc.) and how they will ensure cultural competence	and other factors.		
<b>Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings</b>	<ul style="list-style-type: none"> <li>• CCO has a significant percentage of members enrolled in patient centered primary care homes (PCPCHs) certified at least as Tier 1 according to Oregon's standards.</li> <li>• CCO demonstrates ability to offer enrollees a comprehensive delivery system network with the PCPCH at the center, with other health care providers and local services and supports under arrangement for comprehensive care management.</li> </ul>	<ul style="list-style-type: none"> <li>• CCO demonstrates that an increasing number of their enrollees will be served by certified PCPCHs and that those PCPCHs will be moving toward Tier 2 and 3 of the Standards.</li> <li>• CCO demonstrates a comprehensive approach to care management by developing meaningful relationships between PCPCHs, the health care community, state and local government, and community services and supports.</li> </ul>	<ul style="list-style-type: none"> <li>• % of members in a PCPCH</li> <li>• % of PCPCHs certified as Tier 3</li> <li>• A delivery system network plan that includes network development activities, on-going management, and technical assistance for providers.</li> <li>• Data that identify utilization by provider type with a plan to address shifts in care within the delivery system.</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
<b>CCO operates in a manner that encourages patient engagement, activation, and accountability for the member's own health.</b>	<ul style="list-style-type: none"> <li>• CCO demonstrates how it will facilitate activation of its enrolled population.</li> <li>• Additional expectations awaiting input from CCO Work Group and policy</li> </ul>	CCO provides resources based on member's Patient Activation level (1, 2, 3 or 4).	<ul style="list-style-type: none"> <li>• CCO assesses members' activation levels)</li> <li>• Activation improvement over time: X% of members improving by Y% in Z amount of time</li> </ul>	

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
	guidance from OHPB			
<b>Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible</b>	<ul style="list-style-type: none"> <li>• CCO develops a process to conduct health screenings for members to assess individual care needs.</li> <li>• Additional expectations awaiting input from CCO Work Group and policy guidance from OHPB</li> </ul>		<ul style="list-style-type: none"> <li>• X% of members receive health screen in year 1</li> <li>• X% of high risk members have individualized care plan in year 1</li> <li>• % of eligible members have a personalized care plan established within X days of enrollment</li> </ul>	
<b>Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long term care setting</b>	<ul style="list-style-type: none"> <li>• CCO develops plan to address transitional care for members facing admission or discharge from hospital, hospice or other palliative care, home health care, adult foster care, or skilled nursing care.</li> <li>• Additional expectations awaiting input from CCO Work Group and policy guidance from OHPB</li> </ul>	CCO has ability to track member transitions from one care setting to another, including engagement of the member and family members in care management and treatment planning. Tracking system may include appropriate follow-up guidelines, alerts, and reporting.	<ul style="list-style-type: none"> <li>• Follow-up after hospitalization: % discharged from inpatient care who have a follow-up visit within X days</li> <li>• Care Transition Measure (CTM-3): 3-item questionnaire measuring quality of patient preparation for transitions (understanding own role; medication reconciliation; incorporation of personal preferences into care plan)</li> </ul>	
<b>Members receive assistance in navigating the health care delivery system and in accessing community and social support services and</b>	<ul style="list-style-type: none"> <li>• CCO provides access to non-traditional health workers, and assists members to navigate the health care system and gain access to</li> </ul>	All CCO members have full support in navigating the health care system and other community services and supports that may be provided by both traditional and non-traditional health	<ul style="list-style-type: none"> <li>• Ratio of non-traditional health workers to enrollees</li> <li>• % of members assigned to a non-traditional provider(s) that is appropriate for their</li> </ul>	

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b>statewide resources, including through the use of certified health care interpreters, community health workers and personal health navigators who meet competency standards established by the Authority</b></p>	<p>additional community services and supports.</p> <ul style="list-style-type: none"> <li>• Additional expectations awaiting input from CCO Work Group and policy guidance from OHPB</li> </ul>	<p>workers.</p>	<p>needs</p>	
<p><b>Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations</b></p>	<ul style="list-style-type: none"> <li>• CCO has a delivery system network that provides appropriate access to needed health care services close to where members reside that may also include non-traditional settings and community services and supports.</li> <li>• Additional expectations awaiting input from CCO Work Group and policy guidance from OHPB</li> </ul>	<ul style="list-style-type: none"> <li>• CCO manages a comprehensive delivery system network based on patient-centered primary care homes and inclusive of non-traditional settings.</li> <li>• CCO identifies underserved populations and addresses their health disparities, adjusting services and settings to match their needs.</li> </ul>		
<p><b>Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable</b></p>	<ul style="list-style-type: none"> <li>• CCO documents its level of HIT/HIE infrastructure and competency, develop a plan for meeting transformation expectations, and work towards improvements.</li> </ul>	<p>CCO has HIE capacity to relay patient information in real time from a member's PCPCH to other parts of the delivery system in order to fully support care coordination and management.</p>	<ul style="list-style-type: none"> <li>• % providers/entities within CCO that meet Meaningful Use criteria</li> <li>• % of CCO members who have an EMR or EHR</li> </ul>	

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<b>CCO complies with safeguards for members as described in Section 8, Consumer and Provider Protections, of HB 3650</b>	CCO adheres to safeguards for members as described in Section 8 of HB 3650.	CCO adheres to safeguards for members as described in Section 8 of HB 3650. In addition, CCO supports members by carrying out (1)(a) – (e) to the greatest extent feasible.		
<b>Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of the membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met</b>	<ul style="list-style-type: none"> <li>• CCO establishes a CAC through a process that assures diverse community representation.</li> <li>• CCO employs best practices to support engagement and participation of members, including those facing barriers to participation.</li> </ul>	CCO assures collaboration between the CAC and the governing board on policy formulation and other decision-making affecting patient care and health outcomes.	<ul style="list-style-type: none"> <li>• Attendance of CAC members and consideration of CAC recommendations in Board meeting in minutes</li> </ul>	
<b>Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions</b>	<ul style="list-style-type: none"> <li>• A substantial percentage of high risk members have an individualized care plan</li> <li>• Additional expectations awaiting input from CCO Work Group and policy guidance from OHPB</li> </ul>	<ul style="list-style-type: none"> <li>• CCO develops a system to identify and track high-risk members and their outcomes, including avoidable ED visits and hospital admissions.</li> <li>• Provider network capacities are adjusted to reflect changes in the need for and use of preventive services, remedial and supportive care, emergency care, and hospital care.</li> </ul>	<ul style="list-style-type: none"> <li>• Rate of avoidable hospitalizations</li> <li>• Rate of non-emergent ED visits</li> <li>• Measures of patient engagement or patient activation</li> </ul>	

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b>Members have <i>access</i> to a choice of providers within the CCO's network and that providers in the network:</b></p> <ul style="list-style-type: none"> <li>• <b>work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members</b></li> <li>• <b>are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history</b></li> <li>• <b>emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication</b></li> <li>• <b>are permitted to participate in networks of multiple CCOs</b></li> <li>• <b>include providers of specialty care</b></li> <li>• <b>are selected by CCOs using universal application and credentialing procedures, objective quality</b></li> </ul>	<p>AWAITING SPECIFIC details from discussion at the CCO Criteria Work Group</p>			

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p>information and removed if providers fail to meet objective quality standards</p> <ul style="list-style-type: none"> <li>work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members</li> </ul>				
<p>Each CCO reports on outcome and quality measures identified by the Authority under Section 10 and participates in the All Payer All Claims data reporting system</p>	<ul style="list-style-type: none"> <li>CCO reports an acceptable level of performance with respect to identified metrics</li> <li>CCO submits APAC data in timely manner according to program specifications</li> </ul>	<p>CCO reports exceptional performance with respect to identified metrics</p>	<ul style="list-style-type: none"> <li>Patient experience of care</li> <li>Hospital readmission rates</li> <li>Access (e.g. time from CCO enrollment to first encounter, and type of encounter)</li> <li>HbA1C control</li> <li>Etc.</li> </ul>	<ul style="list-style-type: none"> <li>Data timeliness</li> <li>Availability of clinical data</li> </ul>
<p>CCO is transparent in reporting progress and outcomes.</p>	<ul style="list-style-type: none"> <li>CCO provides OHA with detailed quality, efficiency, and outcome data (not aggregate results)</li> <li>CCO has performance feedback loop to contracted entities and providers</li> <li>CCO makes aggregate performance information</li> </ul>	<p>CCO has system in place to provide timely performance and outcomes data to all stakeholders</p>		

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
	available to members			
<b>Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks</b>	AWAITING SPECIFIC details from discussion at the CCO Criteria Work Group and policy guidance from the OHPB			
<b>Each CCO participates in the learning collaborative described in ORS 442.210</b>	CCO participates in the learning collaborative described in ORS 442.210 that engages state and local government, private health insurance carriers, third party administrators, patient centered primary care homes, other critical health care providers, and community and social support services.			
<b>Each CCO has a governance structure that includes:</b> <ul style="list-style-type: none"> <li>• a majority interest consisting of the persons that share the financial risk of the organization</li> <li>• the major components of the health care delivery system, and -the community at large, to ensure that the organization's</li> </ul>	CCO clearly articulates selection criteria for governing members and assures transparency in governance—who the decision makers are, how decisions are made and how decision-making is linked with the work of the Community Advisory Council		<ul style="list-style-type: none"> <li>• Feedback from the Community Advisory Council</li> <li>• Member experience or satisfaction surveys</li> </ul>	

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p>decision-making is consistent with the values of the members of the community</p>				
<p>The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.</p>	<ul style="list-style-type: none"> <li>• CCO has plans for developing and maintaining linkages between local government agencies and other nonprofit agencies in the configuration of CCOs.</li> <li>• Additional expectations awaiting input from CCO Work Group and policy guidance from OHPB</li> </ul>			
<p>On or before 7/1/14, each CCO will have a formal contractual relationship with any DCO in its service area</p>	<p>CCO has a plan for forming contractual relationships with any DCO in its serve area on or before 7/1/14.</p>	<p>CCO has taken concrete steps towards forming contractual relationships with any DCO that services members of the CCO in the area where they reside on or before 7/1/14.</p>		
<p>OHA encourage CCOs to use alternative payment methodologies that:</p> <ul style="list-style-type: none"> <li>• reimburse providers on the basis of health outcomes and quality measures instead of the volume of care</li> <li>• hold organizations and providers responsible for the efficient delivery of</li> </ul>	<p>Expectations will be developed with input from CCO Work Group and policy guidance from OHPB</p>			

## DRAFT: Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Workgroups' Discussions and Other Public Input as of 10/7/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p>quality care</p> <ul style="list-style-type: none"> <li>• reward good performance</li> <li>• limit increases in medical costs</li> <li>• use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination</li> </ul>				
<p><b>Each CCO shall implement, to the maximum extent feasible, patient-centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.</b></p>	<ul style="list-style-type: none"> <li>• CCO works with participating Patient-Centered Primary Care Homes (PCPCHs) to develop a comprehensive Delivery System Network (DSN) and to assure effective person-centered care planning and coordination which may be evidenced by a plan.</li> <li>• Additional expectations awaiting input from CCO Work Group and policy guidance from OHPB</li> </ul>		<ul style="list-style-type: none"> <li>• x% of CCOs' primary care network is PCPCH by end of year 1</li> <li>• x% of primary care network is Tier 3 PCPCH by year 3</li> </ul>	

# Proposed Business Plan Outline: House Bill 3650 Health Care Transformation

10/07/2011 DRAFT

## 1. Executive Summary

## 2. Existing Market Environment and Industry Analysis

- a. Medicaid programs, populations, and delivery structures
  - i. Managed care
  - ii. Fee-for-service
  - iii. Long term care and community supports and services
  - iv. Behavioral health care
  - v. Case management and other targeted Medicaid programs
  - vi. Individuals who are dually eligible
- b. Opportunities for improving health outcomes and quality of care, reducing health disparities and the costs of providing care
  - i. Coordination and alignment between CCOs and long term care services and supports
  - ii. Improved use of health information technology
  - iii. Reduced regulatory conflicts between Medicare and Medicaid
  - iv. Alignment with PEBB/OEBB
    - 1. CCOs as a platform for future PEBB/OEBB contracting
    - 2. Key steps PEBB/OEBB are taking to align with CCO development
  - v. Alignment with Oregon's Health Insurance Exchange products and federal essential health benefits
  - vi. Alignment with private sector initiatives

## 3. Product Being Offered: Coordinated Care Organizations

- a. CCO definition and service offering
- b. CCO criteria reflecting work to be performed by CCOs as identified in HB 3650

## 4. Product Ownership & Management: CCO Governance and Community Participation

- a. CCO Governance Structure
  - i. Governing Board
  - ii. Community Advisory Board
  - iii. Partnerships
- b. Health Equity and Community Engagement

- i. Defining avoidable gaps in health care outcomes and experiences
- ii. Key CCO expectations and opportunities for improving health equity and reducing disparities
- iii. Role of community in reducing avoidable health disparities

**5. Plan of Operations: Payment and Accountability**

- a. Global Budget Methodology
  - i. Definition of programs and funding to be included in initial global budgets and flexibilities for additional program inclusion and funding in individual CCO budgets.
  - ii. Method for adjusting global budgets based on member risk profiles and opportunities for CCOs to share risk with the state.
  - iii. Virtual integration, risk sharing, or other arrangement for financial alignment with long term care.
  - iv. Incorporation of Medicare funding streams for dually eligible individuals.
  - v. Overall rate setting process and actuarial soundness review.
- b. Metrics
  - i. Goals/purpose for accountability metrics
  - ii. Implementation / staging plan for CCO performance measurement
    - 1. Explanation of how metrics will be linked to contracting, budget, and/or incentives
    - 2. Anticipated schedule for reporting and assessment of performance
    - 3. Explanation of minimum performance expectations and targets, as applicable
    - 4. Scoring, weighting, and/or prioritization of metrics for operational purposes
    - 5. Schedule and process for revising metrics over time
  - iii. Initial set of CCO accountability metrics
    - 1. Core metrics (required of all CCOs) and data source
    - 2. Menu metrics (CCO choice) and data source
    - 3. Test or developmental metrics (required but limited accountability for performance) and data source
- c. Financial reporting requirements
  - i. CCO financial reporting elements specified in HB 3650;
  - ii. Single reporting of financials
  - iii. Plan for financial viability of CCOs
    - 1. Criteria elements identified by OHPB;

2. Relevant and useful financial reporting requirements currently part of DMAP oversight of OHP contracting health plans, and currently part of DCBS oversight of commercial insurers and Medicare Advantage plans

## **6. Implementation Plan: Transition to CCOs**

- a. Call for applications and certification/contracting process
- b. Contingency plans
  - i. For areas with multiple qualified CCOs
  - ii. For areas with no qualified CCOs
- c. Mechanisms for transitioning clients to CCOs
  - i. Consumer protections

## **7. Outreach and Public Engagement Plan**

- a. Legislative engagement
- b. Marketing plan
  - i. Outreach to potential CCO applicants and communities
  - ii. Consumer awareness and education
- c. OHA rulemaking
- d. Timeline for public reporting on CCO performance as required by HB 3650
- e. Ongoing public and consumer feedback

## **8. Financial Projections: Potential Savings**

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

## **9. Appendices**

- a. Detailed CCO criteria
- b. Alternative dispute resolution
  - i. Identify alternatives for resolution of disputes between providers and CCOs.
  - ii. Select alternative(s) best suited to timely and effective resolution
  - iii. Identify responsibilities of parties involved
  - iv. Explore feasibility of addressing alternative dispute resolution in CCO contracts

- c. Overview of CMS design proposal for integration and coordination of health care delivery systems for individuals who are dually eligible

**Note regarding HB 3650 Section 16 Health care cost containment:**

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

DRAFT

# State of Equity Report to the Oregon Health Policy Board

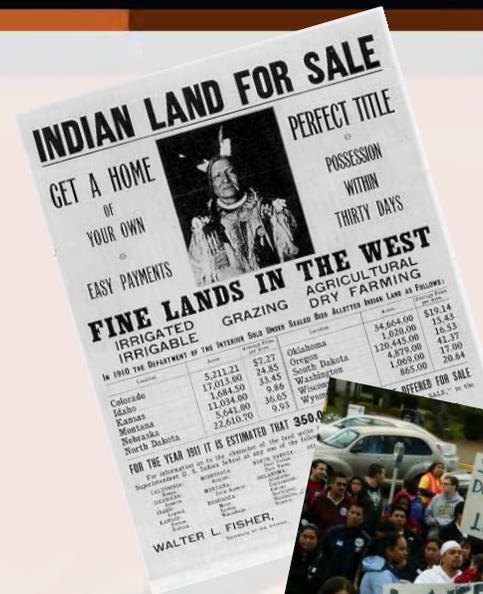


Oregon  
**Health**  
Authority

October 11, 2011  
Tricia Tillman, MPH

**Health inequities** are systemic, avoidable, unfair and unjust differences in health status and mortality rates and in the distribution of disease and illness across population groups.

They are sustained **over time and generations** and **beyond the control of individuals.**



**Health equity** is attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary socially patterned injustices, and the elimination of health disparities.



The Department of Health and Human Services

# Recommendations

## 2000 Governor's Racial and Ethnic Health Task Force

“The availability of sufficient data on racial and ethnic communities is key to positioning the state to compete for new sources of funding and determine a level of priority in decision-making processes.”

*Governor's Racial and Ethnic Health Task Force, Final Report. November 2000.*

# **Recommendations**

**2007 Oregon Health Fund Board**

**Health Equity Committee**

Expanded data collection and analysis

**2011 Governor's Task Force on  
Disproportionality in Child Welfare**

**"The Road to Equity" Report**

# Other Recommendation Drivers

- **Community Drivers**

- ***State of Black Oregon*** - Urban League of Portland, 2009
- ***An Unsettling Profile*** – Coalition of Communities of Color, 2009

- **National Health Care Drivers:**

- ***Assuring Healthcare Equity: A Healthcare Equity Blueprint***- National Public Health and Hospital Institute and National Association of Public Hospitals and Health Systems in collaboration with the Institute for Health Care Improvement, 2008
- ***NCQA Multicultural Standards & Guidelines***

# Oregon's Action Plan for Health

December 2010



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# State of Equity Report Purpose

- Describe differences by race and ethnicity in
  - Need
  - Access
  - Customer service quality
  - Outcomes

# State of Equity Report

## Phase 1 Objectives

- Assess availability and quality of data on DHS/OHA Key Performance Measures (KPMs) by race and ethnicity
- Assess feasibility of compiling KPMs by race/ethnicity across DHS/OHA
- Support organizational culture change
  - Race and ethnicity as standard consideration

# 25 OHA-Specific KPMs

Division	Calculated	Too Little Data to Interpret	Could Calculate with Additional Resources	Data Not Available
Addictions and Mental Health	8	3	1	0
Division of Medical Assistance Programs	3	0	0	0
Oregon Health Policy and Research	1	0	0	0
Public Health Division	6	1	1	1
<b>TOTAL</b>	<b>18</b>	<b>4</b>	<b>2</b>	<b>1</b>

# Quality of Data on Race/Ethnicity

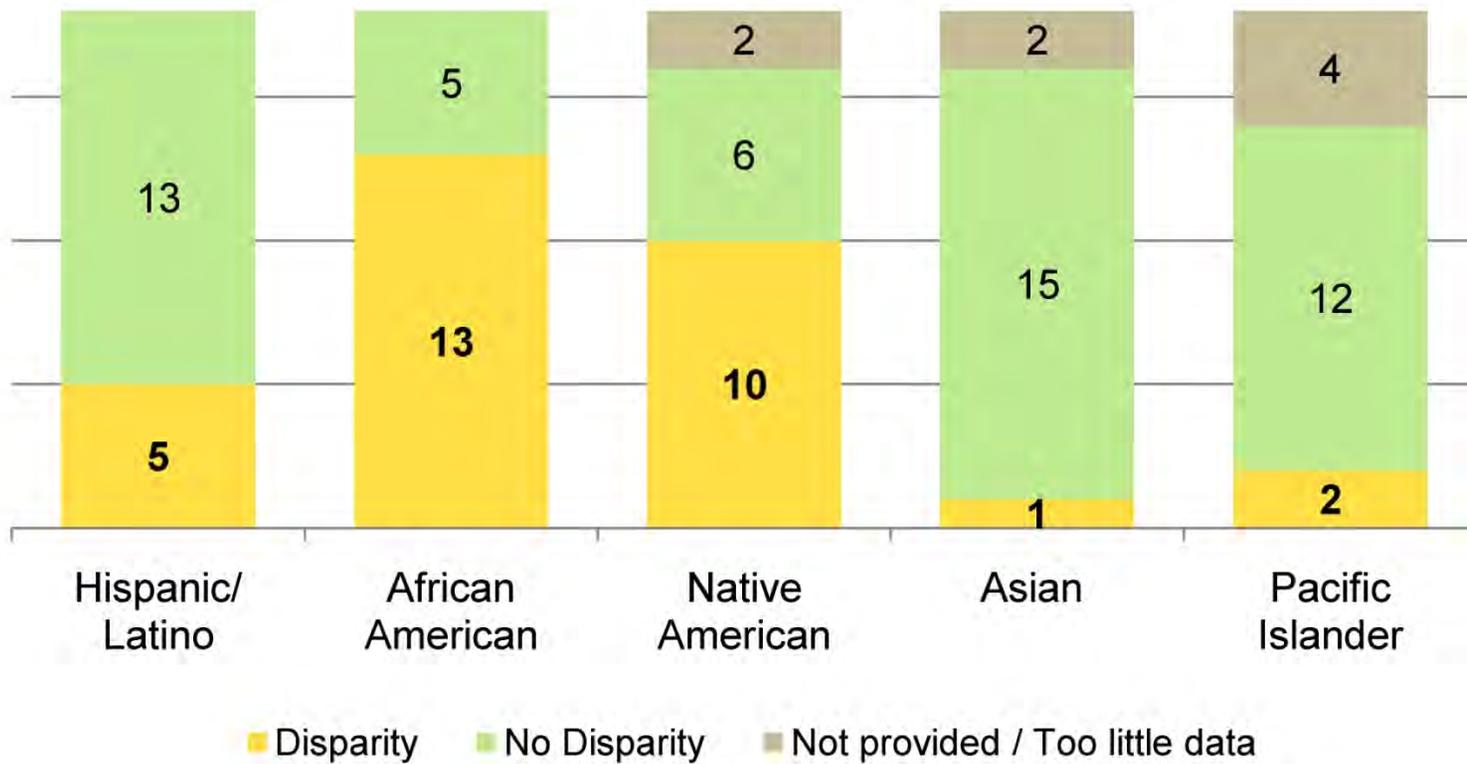
- Racial/ethnic categories generally consistent with federal guidelines, but variability in how data collected and reported across divisions (e.g., for those identifying as multiracial)
- Some data systems have large number of “missing/unknown” for race

# Interpretation of Results

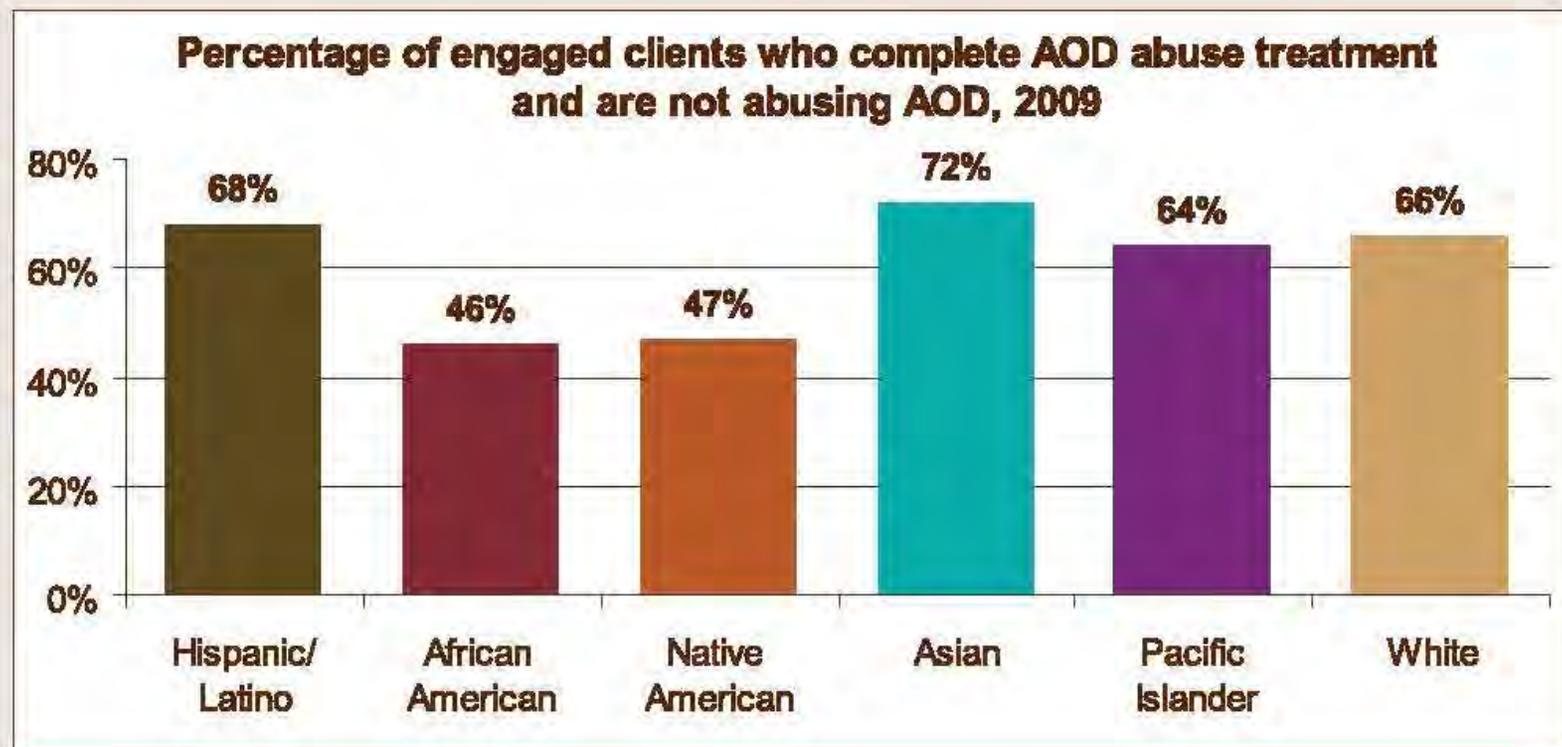
## Divisions determined if:

- No disparity: Little or no disparity compared to non-Latino Whites
- ▲ Disparity: Findings suggest disparities between at least one community of color and non-Latino Whites
  - Further analysis of possible reasons and remedial interventions needed
  - Disparities could be influenced by many factors (e.g., co-morbidities) so should not view disparities as result of single cause

## Summary of Racial/Ethnic Disparities Among 18 KPMs of OHA



# Example KPM: Addictions and Mental Health



# Addictions and Mental Health

**Symbols**

 No Disparity/  
Doing better

 Disparity

**NC**  
Not Calculable

Division	KPM or Related Indicator	Hispanic / Latino	Non-Latino African American	Non-Latino Native American	Non-Latino Asian	Non-Latino Pacific Islander
<b>AMH</b>	Completion of alcohol and drug treatment					
	Alcohol & drug treatment effectiveness - adults					
	Alcohol & drug treatment effectiveness - parents				NC	NC
	Alcohol & drug treatment effectiveness - children				NC	NC
	8th grader use of alcohol					
	8th grader use of illicit drugs					
	Mental health client level of functioning					
	OSH restraint rate			NC		NC

OSH: Oregon State Hospital

# Division of Medical Assistance Programs

Symbols	
	No Disparity/ Doing better
	Disparity
<b>NC</b>	Not Calculable

Division	KPM or Related Indicator	Hispanic / Latino	Non-Latino African American	Non-Latino Native American	Non-Latino Asian	Non-Latino Pacific Islander
<b>D</b> <b>M</b> <b>A</b> <b>P</b>	Preventive services for OHP children					
	Preventive services for OHP youth and adults					
	PQI - hospitalizations of OHP clients					

PQI: Prevention Quality Indicator, rate of ambulatory care sensitive condition hospitalizations

**Symbols**

 No Disparity/  
Doing better

 Disparity

**NC**  
Not Calculable

# Public Health Division

Division	KPM or Related Indicator	Hispanic / Latino	Non-Latino African American	Non-Latino Native American	Non-Latino Asian	Non-Latino Pacific Islander	
<b>PHD</b>	Teen pregnancy						
	Intended pregnancy						
	Early prenatal care	Low-income					
		Non-low-income					
	Tobacco use - adults						
	Tobacco use - children						
	Tobacco use - pregnant women						
	Child immunizations						
	Rate of HIV infection						

# Burden of Disparities: OHA KPMs

**Symbols**

 No Disparity/  
Doing better

 Disparity

**NC**  
Not Calculable

Division	KPM or Related Indicator	Hispanic / Latino	Non-Latino African American	Non-Latino Native American	Non-Latino Asian	Non-Latino Pacific Islander	
AMH	Completion of alcohol and drug treatment						
	Alcohol & drug treatment effectiveness - adults						
	Alcohol & drug treatment effectiveness - parents				NC	NC	
	Alcohol & drug treatment effectiveness - children				NC	NC	
	8th grader use of alcohol						
	8th grader use of illicit drugs						
	Mental health client level of functioning						
	OSH restraint rate			NC		NC	
DMAP	Preventive services for OHP children						
	Preventive services for OHP youth and adults						
	PQI - hospitalizations of OHP clients						
OHPR	Safety net clinic use			NC		NC	
PHD	Teen pregnancy						
	Intended pregnancy						
	Early prenatal care	Low-income					
		Non-low-income					
	Tobacco use - adults						
	Tobacco use - children						
	Tobacco use - pregnant women						
	Child immunizations						
Rate of HIV infection							

# Burden of Disparities: DHS/OHA-wide KPMs

**Symbols**

 No Disparity/  
Doing better

 Disparity

**NC**  
Not Calculable

Division	KPM or Related Indicator		Hispanic / Latino	Non-Latino African American	Non-Latino Native American	Non-Latino Asian	Non-Latino Pacific Islander
DHS / OHA WIDE	Customer Service: Accuracy	Youth					
		Adult					
	Customer Service: Availability of information	Youth					
		Adult					
	Customer Service: Expertise	Youth					
		Adult					
	Customer Service: Helpfulness	Youth					
		Adult					
	Customer Service: Timeliness	Youth					
		Adult					
	Customer Service: Overall	Youth					
		Adult					

# Next Steps

- Phase 1
  - DHS/OHA implementation of Race/Ethnicity and Language (REAL) data collection policy
  - Developing REAL data reporting guidelines
  - Convening community leaders for dialogue

# Next Steps

- Future phases of report
  - Phase 2: Divisions identify 3 – 5 “meaningful” indicators (results expected in January 2012)
  - Phase 3: Community engaged in identifying “meaningful” indicators
  - Health outcomes monitoring, surveillance, and reporting by race/ethnicity becomes standard practice
- Program and policy development with technical assistance to close avoidable gaps in needs, access, and outcomes

# THANK YOU ...

- Program Design and Evaluation Services

- Julie Maher
- Kristen Rohde
- Tim Holbert
- Tara Fechter

- **Addictions and Mental Health Division:** Berhanu Anteneh, Bill Bouska, Jon Collins, Marion David, Madeline Olson, Len Ray, Catherine Reid, and Dagan Wright
- **Children, Adults and Families Division, Self-Sufficiency Program:** Don Bartell, Carole Cole, Peggy Condron, Xochitl Esparza, Robi Henifin, and Jeff Tharp
- **Children, Adults and Families Division, Child Welfare Program:** Gloria Anderson, Anna Cox, Maria Duryea, Sonya Olsen-Hasek, and Mickey Serice
- **Children, Adults and Families Division, Office of Vocational Rehabilitation Services:** Ron Barcikowski and Stephaine Parrish
- **DHS/OHA KPM Coordinator/Transformation Initiative:** Cathy Iles
- **Division of Medical Assistance Programs:** Susan Arbor, Charles Gallia, and Sandy Wood
- **Forecasting, Research and Analysis:** Justin Dickerson, Laurel Goode, Arron Heriford, and Gregory Tooman
- **Oregon Health Policy and Research:** Mary Dinsdale, Sata Hackenbruck, Elyssa Tran, and Joel Young
- **Public Health Division, Adolescent Health Section:** Sarah Ramowski
- **Public Health Division, Office of Environmental Public Health:** Jae Douglas and Dan Rubado
- **Public Health Division, Health Promotion and Chronic Disease Prevention:** Cathryn Cushing and Stacey Schubert
- **Public Health Division, Health Systems Planning:** Nita Heimann
- **Public Health Division, HIV/STD/TB Program:** Sean Schafer
- **Public Health Division, Immunization Program:** Holly Groom, Steve Robison, and Collette Young
- **Public Health Division, Injury Prevention and Epidemiology Section:** Matt Laidler and Lisa Millet
- **Public Health Division, Office of Family Health:** Kathryn Broderick, Ken Rosenberg, and Al Sandoval
- **Public Health Division, Office of Information Services:** Mike Donchi and Courtney Sullivan
- **Seniors and People with Disabilities Division:** Mike McCormick

**Knowing is not enough; we must apply.  
Willing is not enough; we must do.**

Goethe

# Questions?

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OMHS Website:

<http://www.oregon.gov/OHA/omhs/>



October 3, 2011

Dear Oregon Health Policy Board Members,

I am writing to you as a follow up to the Health Equity webinar conducted on September 8, 2011. Along with a number of health care and mental health professionals, community members and advocates who focus on the specific needs of Oregon's diverse communities of race, ethnicity, language, economic status, ability, religion, occupation, gender and sexual orientation, I would like to thank you for your leadership in Oregon's Health Reform efforts share some specific strategies for advancing health equity through the health systems transformation process you have committed to lead.

As you may already know, forty percent (40%) of Oregon Health Plan enrollees are people of color who, along with other culturally and socially diverse groups, continue to face the most disparities in access, quality, and outcomes of care:

- Oregon ranks 38<sup>th</sup> out of 39 states with sufficient data in the number of African American **diabetes deaths** per 100,000 population by race/ethnicity and 31<sup>st</sup> of 39 states with sufficient data in the number of African American number of **deaths caused by stroke and other cerebrovascular diseases.**<sup>i</sup>
- Nationally, the **migrant seasonal farm worker population** has an average life expectancy of only 49 years, living nearly thirty years less than the non-Hispanic, white population.
- **Suicide** is the leading cause of death among LGBT youth, with sexual minority youth being 2-3 times more likely to attempt suicide and comprising 30% of completed suicide. This indicates the severe issues of access to mental and physical health care for LGBT populations.<sup>ii</sup>

State health reform provides an excellent opportunity for renewed focus and commitment to health equity. With diversity increasing among Oregon's OHP and overall populations as well as the unacceptable health disparities these populations face, improving the health outcomes for these communities is critical to a successful transformation of Oregon's health systems. It also falls directly in line with Oregon's triple of aim of 1) improving the lifelong health of *all* Oregonians, 2) increasing the quality, reliability, and availability of care for *all* Oregonians, and 3) lower or contain the cost of care so it is affordable to everyone.

In order to fulfill our mission and meet the needs of our diverse populations, the OMHS Health Equity Policy Committee has outlined several policy opportunities (attached) that if prioritized in the Health Systems Transformation process, will be a concrete step towards reducing health disparities in Oregon.

These opportunities are consistent with the priorities outlined in numerous national efforts to promote health equity, including, but not limited to the following:

- The National Partnership for Action to End Health Disparities
- The Joint Commission's *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*
- The American Medical Association's Ethical Force Program for Patient Centered Communication
- The National Public Health and Hospital Institute, National Association of Public Hospitals and Health Systems, and the Institute for Health Care Improvement's *Assuring Healthcare Equity: A Healthcare Equity Blueprint*
- National Committee for Quality Assurance's Roadmap for Addressing Healthcare Disparities, Multicultural Health Care Distinction Program

Throughout our state's history, Oregonians have had the opportunity to close the gap between the most and least vulnerable. In too many cases, that opportunity has not been seized to the detriment of many individuals, families, communities and our state as a whole. However, today, you can play a critical leadership role in advancing health equity. We encourage you to take full advantage of this opportunity to promote policies through this transformation effort that assure quality and equitable care for all Oregonians.

Thanks again for your leadership and commitment to Oregon's Health Systems Transformation process and to improving the health and well being of Oregon's diverse populations. If you have any questions, need any additional information or resources, please feel free to contact me.

With warmest regards,



Tricia Tillman, MPH  
Administrator  
Office of Multicultural Health and Services

---

<sup>i</sup> Source: Kaiser Family Foundation, 2006

<sup>ii</sup> US Department of Health and Human Service

## Health Equity Opportunities in Health Systems Transformation

	CCO Criteria and Statement of Work	Global Budget	Medicare-Medicaid Integration	Outcomes, Quality and Efficiency
<b>Overarching</b>	<ul style="list-style-type: none"> <li>Strategic Equity Plan with benchmark performance goals</li> <li>Specific leadership assigned to monitor progress toward health equity benchmarks</li> </ul>	<ul style="list-style-type: none"> <li>Strategic Equity Plan with benchmark performance goals tied to specific budget plan that include specific incentives for reducing disparities</li> </ul>		
<b>Access</b>	<ul style="list-style-type: none"> <li>Interpreter/Translation plan and subcontracts</li> <li>Inclusion of “promising practices” language in RFP/statement of work (in addition to “evidence-based”)</li> <li>Supports for clients moving off of coverage and into HIE</li> <li>Assurance that CCO will ensure equal patient access regardless of language, disability, culture and develop a plan to address staffing issues that would best enhance these opportunities</li> </ul>	<ul style="list-style-type: none"> <li>Resources driven to highest risk clients</li> <li>Budget allocation for training, reimbursement of certified/qualified health care interpreters, community health workers, peer wellness specialists, etc.</li> <li>Resources for engaging in efforts to improve social determinants of health in CCO region</li> <li>Request to move from CE to Access: Subcontracts to specific partner organizations serving diverse populations</li> </ul>	<ul style="list-style-type: none"> <li>Development of strong partnerships with Patient Centered Primary Care Homes (PCPCH), including migrant, homeless and community health centers</li> <li>Equitable enrollment in Medical Advantage and Special Needs Plans</li> <li>Mental/behavioral health literacy to address cultural barriers to services</li> <li>Linguistically appropriate information re: dual eligibility, CCO disenrollment if care is inadequate</li> </ul>	<ul style="list-style-type: none"> <li># of LEP consumers</li> <li>Language audit to analyze demand for and provision of linguistically competent services</li> <li>Race/ethnicity data audit (based on Race Ethnicity And Language[REAL] Data standards)</li> <li># or % of comprehensive assessments for dual eligibles, by R/E/L</li> <li># and description of internal policies focused on health equity or provisions</li> <li>Wait time for access to health care interpreters</li> </ul>
<b>Consumer Engagement</b>	<ul style="list-style-type: none"> <li>Governance committee structure/membership</li> <li>Consumer satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>Outreach/engagement resources dedicated to specific communities</li> </ul>	Clear and transparent grievance process describe in multiple formats/flow charts	<ul style="list-style-type: none"> <li>Client/consumer representative advisory board members by Race/Ethnicity/Language</li> </ul>

	<ul style="list-style-type: none"> <li>• Clear grievance procedures translated and offered through multimedia approaches</li> <li>• Leveraging community and faith-based partnerships</li> <li>• Entities should be required to demonstrate, through letters of support strong working relationships across their communities and there should be a penalty if this cannot be reasonably attained.</li> <li>• Processes for collecting community wisdom and experience with health care with links to implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Specific data collection efforts (focus groups, marketing data (SDOHs)</li> <li>• Subcontracts to specific partner organizations serving diverse populations</li> <li>• Have a transparent process for determining and distributing shared savings so their communities may participate or at least understand how these decisions are made and where the savings are being directed</li> </ul>		<ul style="list-style-type: none"> <li>• Consumer satisfaction and grievance linked to REAL data</li> <li>• # of community and faith based partnerships/ subcontracts</li> <li>• # of contract providers who are bi or multilingual or bi-cultural</li> </ul>
<b>Health Care Delivery</b>	<ul style="list-style-type: none"> <li>• Workforce diversity and career path development to increase culturally diverse providers</li> <li>• Utilization of non-traditional health workers (ie/community health workers, peer wellness specialists, etc.)</li> <li>• Provider/staff workforce training on cultural and linguistic competency, health literacy</li> <li>• Certified health care interpreters that provide care to all patient populations according to best practice/evidence-</li> </ul>	<ul style="list-style-type: none"> <li>• Line items for non-traditional health care workers (CHWs, HCIs, Doulas)</li> <li>• Subcontracting with telephonic and/or videoconference interpreter services/translation services/signage</li> <li>• Incentives and pay differentials for providers/interns for culturally diverse backgrounds</li> <li>• Requirement that with global budgeting providers will engage interpreters for patients global budgeting,</li> </ul>	<ul style="list-style-type: none"> <li>• Inclusion of families*** as part of health care team</li> <li>• Self-management care process</li> <li>• Treatment summaries in patient record re: culture, literacy, social supports,</li> </ul> <p>*** “Family” means any person(s) who plays a significant role in an individual’s life. This may include a person(s) not legally related to the individual. Members of “family” include spouses, domestic partners, and both different-sex and same-sex significant others. “Family” includes a minor patient’s</p>	<ul style="list-style-type: none"> <li>• Providers, staff, volunteers, boards, advisory body demographics (race/ethnicity, LGBT/Homelessness)</li> <li>• Cultural and linguistic competence measures</li> <li>• Hours of cultural competence training</li> <li>• Hours of CHW, HCI, Doula utilization</li> </ul>

	<p>based and culturally relevant/sensitive ways</p> <ul style="list-style-type: none"> <li>• System of incentives/disincentives for those that meet/fail to meet standard of care expectations</li> <li>• When CCO is falling behind on expectations they get asked to put together a specific health equity improvement plan and adopt benchmarks and measures</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure diverse staffing that is able to engage populations in best practice/emerging practice approaches that seek to enhance health and reduce health disparities.</li> <li>• Budgets include supporting the client’s personal choice of post long-term care support (in home care provider – family member, close friend, etc.)</li> </ul>	<p>parents, regardless of the gender of either parent. Solely for purposes of visitation policy, the concept of parenthood is to be liberally construed without limitation as encompassing legal parents, foster parents, same-sex parent, stepparents, those serving in loco parentis, and other persons operating in caretaker roles.</p>	
<p><b>Quality Improvement</b></p>	<ul style="list-style-type: none"> <li>• Quality improvement plan should include expectations of performance –based results for addressing health equity outcomes and documentation for services like Certified Health Care Interpreters</li> <li>• Systems designed to capture REAL Data, LGBT</li> <li>• CCOs able to receive technical assistance on how to improve health equity outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>• Budget associated with quality improvement efforts focused on eliminating health care disparities</li> <li>• Establish a payment structure to reward the defined work of provider teams who help their patients achieve better health, while accounting for patients’ complex psycho-social factors as well as their complex medical factors.</li> </ul>	<ul style="list-style-type: none"> <li>• Transition plan after long-term care – social supports included</li> <li>• Assuring standardized assessment of needs is culturally and medically comprehensive</li> <li>• Identification and enhancement of existing family, community and social supports and protective factors, as well as key challenges (including social determinants of health)</li> <li>• Effective data sharing and appropriate utilization of REAL data to identify potential and existing health disparities</li> </ul>	<ul style="list-style-type: none"> <li>• Data sets cut by race, ethnicity, language, sexual orientation, etc.</li> <li>• Wait time for access to health care interpreters</li> <li>• Member satisfaction surveys with questions on cultural respect, linguistic access, etc.</li> <li>• Specific health outcomes across the lifespan by race, ethnicity, language, sexual orientation, housing status etc.</li> <li>• From CAHPS Health Plans &amp; Systems survey: <ul style="list-style-type: none"> <li>○ Provider communication composite</li> <li>○ Customer service composite (treated with courtesy &amp; respect) / Cut by Race/Ethnicity/language</li> </ul> </li> </ul>

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# OHA KPMs for the Phase 1 State of Equity Report

Division	KPM or Related Indicator	Calculated	Not Calculated
AMH	<b>Completion of alcohol and drug treatment:</b> Percentage of engaged clients who complete alcohol and other drug (AOD) abuse treatment and are not abusing AOD	✓	
	<b>Alcohol &amp; drug treatment effectiveness - adults:</b> Percentage of adults employed after receiving alcohol and drug treatment	✓	
	<b>Alcohol &amp; drug treatment effectiveness - parents:</b> Percentage of parents who have their children returned to their custody after receiving alcohol and drug treatment	✓	
	<b>Alcohol &amp; drug treatment effectiveness - children:</b> Percentage of children whose school performance improves after receiving alcohol and drug treatment	✓	
	<b>8th grader use of alcohol:</b> Percentage of 8th graders who have used alcohol within the past 30 days	✓	
	<b>8th grader use of illicit drugs:</b> Percentage of 8th graders who have used illicit drugs within the past 30 days	✓	
	<b>Child mental health services:</b> Percentage of children receiving mental health services who are suspended or expelled from school (Data not available) *		
	<i>Similar to KPM:</i> <i>Percentage of children receiving mental health services who are suspended from school prior to / after onset of most recent mental health service</i>		Too little data
	<i>Similar to KPM:</i> <i>Percentage of parents/guardians reporting their child's school attendance improved after mental health treatment</i>		
	<b>Adult mental health services:</b> Percentage of adults receiving mental health services who report improved functional outcomes as a result of those services		Too little data
	<b>Mental health client level of functioning:</b> Percentage of mental health clients who maintain or improve level of functioning following treatment	✓	
	<b>Gambling treatment effectiveness:</b> Percent of adults who gamble much less or not at all 180 days after ending problem gambling treatment		Could calculate with additional resources
	<b>OSH restraint rate:</b> Number of restraints per thousand patient hours at Oregon State Hospital	✓	
	<b>OSH length of stay:</b> Average length of stay for civil commitments at Oregon State Hospital		Too little data
<b>OHPR</b>	<b>Safety net clinic use:</b> Percentage of uninsured Oregonians served by safety net clinics	✓	

\* Data not available for this KPM, so a similar measure is presented.

# OHA KPMs for the Phase 1 State of Equity Report

Division	KPM or Related Indicator	Calculated	Not Calculated
D M A P	<b>Preventive services for OHP children:</b> Utilization rate of preventive services for children birth through 10 years old covered by OHP	✓	
	<b>Preventive services for OHP youth and adults:</b> Utilization rate of preventive services for youth and adults 11 years old and older covered by OHP	✓	
	<b>PQI - hospitalizations of OHP clients:</b> Rate of ambulatory care sensitive condition hospitalizations of Oregon Health Plan clients	✓	
P H D	<b>Teen suicide:</b> Rate of suicides among adolescents per 100,000		Too little data
	<b>Teen pregnancy:</b> Number of female Oregonians ages 15-17, per 1,000 who are pregnant	✓	
	<b>Intended pregnancy:</b> Percentage of births where mothers report that the pregnancy was intended	✓	
	<b>Early prenatal care:</b> Percentage of low-income women who initiated prenatal care in the first 3 months of pregnancy compared to non-low-income women	✓	
	<b>Tobacco use - adults:</b> Tobacco use among adults	✓	
	<b>Tobacco use - children:</b> Tobacco use among children (8th grade)		
	<b>Tobacco use - pregnant women:</b> Tobacco use among pregnant women		
	<b>Cigarette packs sold:</b> Number of cigarette packs sold per capita		Data not available
	<b>Child immunizations:</b> Percentage of 24 - 35 month old children who are adequately immunized	✓	
	<b>Influenza vaccinations for seniors:</b> Percentage of adults aged 65 and over who receive an influenza vaccine		Could calculate with additional resources
	<b>HIV / AIDS:</b> Proportion of reported HIV/AIDS cases interviewed by a local or state public health professional and offered assistance with partner notification and referral to HIV treatment (Data not available) *		
	<i>Previous KPM:</i> <i>The annual rate of HIV infection per 100,000 persons</i>	✓	

\* Data not available for this KPM, so a similar measure is presented.

# Health Information Technology Oversight Council

## Report to OHA Director, September 30th, 2011

Below is a summary of HITOC and related workgroups, panels and stakeholder meetings from August 6<sup>th</sup> through September 30<sup>th</sup>, 2011. Full meeting summaries are available through the Office of Health Information Technology (OHIT).

**August 24<sup>th</sup>, Finance Workgroup:** Staff gave an update on HB 3650 workgroups, and there was discussion about potential implications of CCOs on HIE financing. Staff disseminated feedback received from CMS on financing issues and the potential for CMS Medicaid funding to support HIE in Oregon. Staff presented materials summarizing Vermont's claims tax that supports funding for HIT and HIE and how it might be relevant to Oregon's future options as current provider and premium taxes approach expiration at the end of the biennium.. Workgroup members began a discussion about additional HIE services beyond Oregon's planned core services and their potential value to users including future CCOs.

**September 8<sup>th</sup>, HITOC:** Council members received updates on the HIE technology services RFP, the Legislative Report, the long-term care HIT/HIE survey, OHIT staffing, the HIE Participation Agreement development, the AIM Conference, HIE finance, and lab reporting and e-prescribing efforts; and received program reports from the Medicaid EHR Incentive Program and O-HITEC (Oregon's regional extension center for EHRs). HITOC voted on a staff recommendation from the Office of Health IT to table the proposed administrative rules to implement the opt-out consent policy for HIE at this time. Their considerations included 1) the need to align our HIE policy efforts with the CCO development efforts underway, 2) consent management technology is still being developed nationally, 3) stakeholder feedback received during the public comment process indicated staff needs more time to gather information and engage stakeholders to better understand the complexities of implementing the consent policy, and 4) the phased approach to HIE being taken in Oregon, beginning with secure Direct messaging services, allows more time to develop an implementation plan for the opt-out policy that will be needed in a more robust, query-based HIE environment. The consent rule-making process will be re-initiated when appropriate given developments in any of these areas. HITOC then received an overview of the Transformation work groups and process from Sean Kolmer, and discussed the implications of CCOs for HIE and HITOC's potential role in CCO planning efforts.

**September 15<sup>th</sup>, HIO Executive Panel:** The Panel received updates on the development of Oregon's health information exchange (HIE) consent rulemaking, participation agreement development, interstate HIE planning work, HIE financing developments, and an overview of House Bill 3650/Coordinated Care Organizations. The group was asked by HITOC to provide feedback on the decision to defer implementation of Oregon Administrative Rules on the HIE opt-out consent policy. Panel members expressed that they concurred with the decision to delay. The Panel discussed the process and content of the regional HIO evaluation that is now underway, and members agreed to provide input in response to forthcoming state requests.