

# Oregon Health Policy Board

## AGENDA [REVISED]

January 10, 2012

Market Square Building

1515 SW 5th Avenue, 9th floor

8:30 am to 3:00 pm

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

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll call Consent agenda: 12/13/11 minutes	Chair	X
2	8:35	Update on Medical Liability	Jeanene Smith	
3	8:45	Report on the Non-Traditional Health Workers Subcommittee Recommendations for Workforce Models for New Systems of Care	Carol Cheney Lisa Angus	
4	9:15	Invited Testimony: Tri-County Medicaid Collaborative	George Brown, M.D., Legacy Health	
5	9:45	Financial Projections	Doug Elwell Health Management Associates	
	10:30	Break		
6	10:45	Review of public comment	Tina Edlund	
7	10:55	Proposal Discussion: <ul style="list-style-type: none"><li>• Alternative dispute resolution</li><li>• Accountability</li><li>• Certification process</li><li>• Patient rights, responsibilities, engagement and choice</li><li>• Delivery system</li><li>• Payment methodologies</li><li>• People eligible for both Medicare and Medicaid</li></ul>	Diana Bianco	
	12:30	Lunch break		
8	1:00	Proposal review	Diana Bianco	
9	2:30	Public Testimony	Chair	
10	3:00	Adjourn	Chair	

**Next Meeting:**  
**January 24, 2011**  
**Market Square Bldg.**  
**8:30 to 12:00**



**Oregon Health Policy Board**  
**DRAFT Minutes**  
**December 13, 2011**  
**1pm – 6pm**  
**Market Square Building**  
**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**  
**Portland, OR 97201**

**Item**

**Welcome and Call To Order**

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except Carlos Crespo.

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

**Consent Agenda:**

The Alternative Dispute Resolution Work Group Report, Stakeholder input, Stakeholder Workgroup summaries and the minutes from the November 8, 2011 meeting were unanimously approved.

Chair Eric Parsons announced that December 31 is Eileen Brady's last day as a member of the OHPB.

*The Alternative Dispute Resolution Work group report can be found [here](#), on page 7.*

**Early Learning Council – Pam Curtis**

Pam Curtis spoke about the SB 909 report prepared by Early Learning Council. Curtis said the Council believes child health outcomes and early learning outcomes are not exclusive. She spoke about the overlapping populations of at-risk children in Oregon including children of color as well as those affected by poverty or benefiting from state-funded systems. Curtis said the Council is not requesting a new agency or budget authority, but it is recommending that it be responsible for governing policy direction for a set of programs, including Home Visiting programs, and health and nutrition-related programs.

*The Early Learning Council SB 909 Report can be found [here](#).*

**CCO Implementation Proposal – Bruce Goldberg, Doug Elwell**

Goldberg stressed that the proposal is an initial recommendation; the draft will be revised after the board receives feedback from the legislature and input from public comments. Goldberg said full estimates of the value that can be achieved with the delivery system changes that are being undertaken have not been included in the draft but will be presented at the next OHPB meeting. Doug Elwell said Health Management Associates is working without preconceived benchmarks to determine how much Oregon can save and how long it will take.

*The Draft CCO Implementation Proposal can be found [here](#), starting on page 9.*

**Legislative Concept – Linda Grimms, Sen. Alan Bates, Rep. Tim Freeman**

Linda Grimms presented the Governor's Legislative Concept Request which includes statutory changes that are being proposed.

Sen. Bates said he believes there should be two paths to becoming a CCO because of the short timeline and limited budget. He said there should be a fast track for current MCOs with 5 years or more of experience and a second, slower track on which an organization would prove that it could handle risk, remain financially stable and integrate care. He also said that global budgeting has to be set in a way that's reasonable and that metrics need to be narrow enough to be meaningful.

Rep. Freeman stressed the importance of community in the roles of CCOs. He said CCOs must be allowed enough flexibility for innovation while still having enough accountability. Rep. Freeman said the CCO governance model could include a majority that has to bear the financial risk, as well as community at-large members. He commented on the Community Advisory Council, suggesting that it could include representations of community and county government but consumers should make up majority. Rep. Freeman said counties need to be involved in the CCO process and that there should be regular meetings that are open to the public.

*The Governor's Legislative Concept Request can be found [here](#), on page 69.*

### **Medical Liability Work Plan – Jeanene Smith, Michelle Mello, Kate Baicker, Bill Wright**

Jeanene Smith presented a Medical Liability Project Summary to the Board. Smith said Dr. Mello and her partner Dr. Kachalia are conducting policy studies on medical panels, joint and several liability options, caps on damages, extension of the Torts Claim Act to Medicaid, and Administrative compensation systems. She said Dr. Wright and Dr. Baicker are conducting studies on defensive medicine and overutilization. Smith also said that the OHA and the Oregon Department of Justice has teamed to analyze Section 16 requirements, which includes constitutional limitations of reform options and the Stark Laws.

*The Medical Liability Project Summary can be found [here](#), on page 71.*

### **County Perspective – Tammy Baney**

Tammy Baney, Deschutes County Commissioner, spoke about the county perspective on transformation. She said areas should not be divided by county boundaries but by access to services; people should be able to cross county borders if it's more convenient. Baney said counties can bring benefits like unrestricted General Fund dollars and the ability to write grants to the table. She stressed that counties need to have a say in what is trying to be achieved and that communities need to be involved in the process.

### **November Stakeholder Group Feedback – Tina Edlund**

Tina Edlund highlighted stakeholder feedback for each of the work groups, which included:

- Coordinated Care Organization Criteria
  1. Best patient engagement approaches should be determined and a community needs assessment should be developed to identify barriers.
  2. OHA should provide a clearinghouse of innovations and best practices, including patient engagement and activation tools.
  3. CCOs need to ensure access on a primary care level and access to specialty care.
- Global Budget Methodology
  1. A focus on social determinants of health will result in more savings
  2. Include as many programs as possible, but avoid compromising local financing or overall service capacity for both Medicaid and non-Medicaid beneficiaries.
- Outcomes, Quality and Efficiency Metrics
  1. OHA should offer incentives first and penalties later.
  2. Metrics must be strongly associated with accountability.
- Medicare-Medicaid Integration of Care and Services
  1. Flexibility and prescriptiveness has to be balanced.
  2. Shared accountability will require better communication and data-sharing between CCOs and LTC; alignment of state rules and regulations; and tracking of appropriate performance metrics.

*The Presentation on Work Group Summaries can be found [here](#).*

### **Health Systems Transformation and Long Term Care – Susan Otter**

Susan Otter gave a presentation on Health Systems Transformation and Long Term Care for Individuals Dually Eligible for Medicare and Medicaid. She highlighted spending for dually-eligible individuals and the opportunities and potential savings that including dual eligible Medicare funding in CCOs could offer. Otter also presented potential models for shared accountability structures.

*The Presentation on Health Systems Transformation and Long Term Care can be found [here](#).*

### **HIT/HIE – Carol Robinson**

Carol Robinson presented HITOC's Advice and Input on Health IT in Proposed CCOs. She spoke about HITOC's approach, which includes meeting providers where they are now and requiring improvement over time, aligning CCO requirements with federal incentives for HIT, allowing for regional variance in HIT maturity but leveraging maximum advantages of HIT for all providers and encouraging innovation to explore HIT applications in a value-based environment. Robinson also highlighted the challenges that

CCOs face including, interoperability vs. interoperability, case management functionality in existing EHRs, providers may not have the same incentives for HIT adoption, and provider-level vs. organizational level tools.

*The Office of Health Information Technology Presentation can be found [here](#).*

### **Systems Transition, Financial Solvency and Accountability – Diana Bianco**

Diana Bianco revisited items that were discussed at last month's meeting to ensure clarity and accuracy, and then lead a discussion of the Proposal that focused on systems transition, financial solvency and accountability.

*The Draft Coordinated Care Organization Implementation Proposal can be found [here](#).*

### **Next Steps Timeline – Chair**

Chair Eric Parsons discussed the timeline: an open period for public comment, discussion during the next meeting on Jan. 10 and then proposal to the Legislature.

### **Public Testimony – Chair**

The board heard public testimony from 11 people:

- Deborah Loy, Capitol Dental Care, expressed concern that oral health be represented in the CCO plan. She said the metrics do not speak to oral health and that dentists need help to transition to global budgets.
- Mike Saslow, Consumer Advisory Panel for HITOC, spoke about using templates in e-mail exchange.
- Paula Hester, Oregon School Based Healthcare Network, encouraged the Board to include school-based health centers as providers. She said the suggested language should be changed to make their inclusion a requirement.
- Arthur Towers, SEIU Local 503, spoke about workforce metrics. He said workers should be given a chance to advocate for their consumers. He also said consumer choice is the best way to ensure cultural competency of CCOs.
- Ann Morrill, Oregon Foundation for Reproductive Health, said preventative reproductive health should have a secure role in primary care. She said prevention of unintended pregnancies in Oregon is one of the most cost-effective initiatives in primary care and preventative reproductive care should be explicitly included in the CCO model.
- Tracy Zitzelberger, Oregon Foundation for Reproductive Health, said that the core metrics omit family planning and women's reproductive health and urged the Board to remedy this omission.
- Dr. Susan Cooksey, Oregon Foundation for Reproductive Health, said contraception and pre-contraceptive care need to be a part of the metrics because almost half of all Oregon pregnancies are unintended.
- Paula Abrams, NARAL Pro-Choice, spoke about the financial costs in relation to unintended pregnancies. She said 61% of the births from unintended pregnancies were publicly funded.
- Miriam Rosenthal, Oregon Foundation for Reproductive Health, said it's very important that preventive measures for women need to be included in the core metrics.
- Carolynn Kohout, a personal health navigator, said she wanted to locate the curriculum committee and she was thankful to be at the board meeting.
- Jim Carlson, Oregon Health Care, said there are existing models in private companies that

successfully show how to coordinate care. He also said 100% of the funds for Medicaid and Medicare are directly or indirectly managed by the state of Oregon.

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

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

## **Adjourn**

### **Next meeting:**

**January 10, 2012**

**8:30 a.m. to 3:00 p.m.**

**Market Square Building**

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

**Portland, OR 97201**

# Health Information Technology Oversight Council

## OHA Director's Report, January 6, 2012

Below is a summary of Health Information Technology Council (HITOC) and related workgroups, panels and stakeholder meetings from Dec. 10, 2011 – Jan. 5, 2012. Full meeting summaries are available on the HITOC website at: <http://www.oregon.gov/OHA/OHPR/HITOC/index.shtml>.

**Dec. 14, 2011: Consent Implementation Subcommittee:** The Consent Implementation Subcommittee was convened to provide input and advice to staff on how to operationalize the opt-out consent policy for health information exchange (HIE) through Oregon Administrative Rule. During their second meeting on Dec. 14, 2011, Subcommittee members received a presentation on Direct HIE Services and discussed possible definitions for HIE and policy options for implementing opt-out for HIE. Subcommittee members reached consensus that the opt-out policy should not be applied to point-to-point HIE, and there was agreement with the ONC Privacy and Security Tiger Team recommendation that in a query or centralized HIE environment where the disclosing provider does not have control over access to their patient's information, patients should be given the opportunity to opt-out of participation. A challenge will be devising policies for HIE models that are not yet well-established or operational in Oregon.

**December 15, 2011: Finance Workgroup Webinar:** Workgroup members reviewed the feedback from the October meeting wherein select workgroup members and other stakeholders met to perform an in-depth analysis of the health information exchange (HIE) savings document. The feedback suggested remaining skepticism about the productivity improvements portion of the analysis, but that the group agrees with the avoided services portion of the analysis. Staff presented an overview of a recent survey of Oregon's regional health information organizations, workgroup members noted that there may be issues with Epic systems communicating with non-Epic systems. Oregon's HIE services vendor, Harris gave a demonstration of Direct messaging.

**January 5, 2012: HITOC:** Council members received updates regarding the HIE Technology Services contract, executed December 30; the Health Policy Board's response to HITOC's advice and input on CCOs; the work of the Consent Implementation Subcommittee and the Finance Workgroup; the state's support for organizations pursuing CMMI Innovation Challenge Grant opportunities; the Oregon Medicaid EHR Incentive Program, which has made total payments of over \$25 million over the past three months; and the state's lead role in the Western States Interstate HIE Consortium. The group discussed how incentive payments are being used and the value of sharing success stories around meaningful use. Updates also were provided by O-HITEC and about the joint public and private sector work on administrative simplification. The group had a lengthy discussion about developing a state strategic plan for HIT: what makes this the right time to develop a plan, what high-level goals should be included, who to identify as the audience for the plan, how to identify and involve stakeholders, the scope of the plan, and the duration of the plan. The council will further discuss those questions in February and will address plan development at its March retreat.

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# Oregon Health Care Workforce Committee

## Draft Recommendations from:

1. Workgroup on workforce models for new systems of care
2. Subcommittee on Non-Traditional Health Workers

Oregon Health Policy Board Meeting  
January 10, 2012



# Workforce Committee Charter

## Recruit Educate Retain

A quality health care workforce to meet the demand created by expansion in health insurance coverage, system transformation and an increasingly diverse population

- Coordinate efforts to meet demand
- Develop recommendations & action plans for OHPB



# Workforce/ Staffing Models for New Systems of Care

# Workforce for New Models of Care

## OHPB Request:

- Describe promising staffing models and/or workforce roles for CCOs, PCPCHs, or similar integrated, coordinated service delivery organizations
- Identify health care workforce competencies required to implement promising models
- Recommend actions to build those competencies within Oregon's health care workforce

## Process:

- Reviewed the existing literature / recommendations from national bodies
- Conducted key informant interviews with 30+ healthcare professionals, educators, health system administrators, and policy experts in Oregon
- Analysis & development of recommendations in consultation with Committee

# Key Message - Workforce for New Models of Care

## **Interprofessional team-based care is the optimal model for integrated and coordinated health care**

“When multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care” (WHO, 2010)

- Interprofessional team-based care enables the processes and outcomes that CCOs and PCPCHs are intended to achieve: comprehensive, integrated, whole-person care, improved efficiency, and better patient health
- Oregon expert: *“A strong primary care foundation is essential for an effective health care system...The Patient Centered Primary Care Home is now widely recognized as the model for strengthening primary care. It requires an interdisciplinary team.”*

# Competencies - Workforce for New Models of Care

Individual competencies for interprofessional team care:

- Communication (interprofessional and provider to client & family)
- Cultural competency
- Roles & responsibilities for collaborative practice, teamwork
- Leadership and change management
- Computer literacy, health information technology (HIT), and use of data for population care management

Organizational competencies for interprofessional team care:

- Flexible reimbursement mechanisms
- Supportive workplace culture – egalitarian & collaborative
- Operational infrastructure – methods for team formation and division of labor, IT systems, and timely data on clients' care and health status
- Community engagement

# Recommendations - Workforce for New Models of Care

## Policy recommendations:

- Establish / expand pilot programs to test alternative payment models
- Develop job descriptions for new positions such as care coordinators, navigators, community health workers, etc.
- Provide opportunities for multi-payer alignment around promising alternative models of reimbursement
- Revise job descriptions for existing categories of health care workers to reflect the nature of inter-professional, team-based care

# Recommendations - Workforce for New Models of Care

## Education recommendations:

- Develop shared methods for training and assessment of interprofessional competencies.
- Provide opportunities for faculty to gain experience with interprofessional practice and new models of care.
- Increase opportunities for interprofessional training, especially in clinical settings
- Set expectations for collaboration between education communities and health care employers
- Collaborate across disciplinary boundaries to develop and implement the same set of interprofessional competencies

# Recommendations - Workforce for New Models of Care

## Practice recommendations :

- Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices.
- Identify successful early adopters of team-based care models to assist practices with transition.
- Prioritize investment in information technology infrastructure.
- Revise hiring and human resources practices to enable recruitment, retention, and evaluation of professionals engaged in interprofessional and team-based care.

## Next steps? - Workforce for New Models of Care

- Public and stakeholder feedback
- Potential online survey or other mechanism to collect input on substance of recommendations as well as best steps/venues for implementing recommendations, targeting:
  - Health care employers and system administrators
  - Practicing educators and trainers
  - Consumers

# Roles, Competencies and Training for Non-Traditional Health Workers

# Charge – Non-Traditional Health Workers

## **HB 3650 Section 11 :**

(1) The Oregon Health Authority, in consultation with the appropriate health professional regulatory boards as defined in ORS 676.160 and advocacy groups, shall develop and establish with respect to community health workers, personal health navigators, peer wellness specialists and other health care workers who are not regulated or certified by this state:

(a) The criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and

(b) Education and training requirements for such individuals.

(2) The criteria and requirements established under subsection (1) of this section:

(a) Must be broad enough to encompass the potential unique needs of any coordinated care organization;

(b) Must meet requirements of the Centers for Medicare and Medicaid Services to qualify for federal financial participation; and

(c) May not require certification by the Home Care Commission.

# Subcommittee – Non-Traditional Health Workers

Members represent health systems, insurers, educational institutions, behavioral health and addictions recovery programs, community clinics, social service and advocacy organizations, and practicing non-traditional health workers from the field.

Process of building draft recommendations included:

- Review of state and national research, existing legislation, published recommendations, and current NTHW programs
- Survey of currently practicing self-identified NTHWs in Oregon, resulting in 620 responses
- Description of scope of work for NTHWs in Oregon → identification of competencies needed to fulfill that scope → recommendations for training aligned with competencies
- Recommendations for certification and oversight

# Scope of work – Non-Traditional Health Workers

## 1. Outreach and Mobilization

Provision of health-related information, resources, and services to ensure that individuals and their natural support systems are informed and able to take action

## 2. Community and Cultural Liaising

Supporting connections among individuals, families, community members, organizations and leaders, providers, and health systems to effectively bridge cultural, health belief, linguistic, geographic and structural differences that limit individuals' ability to access health care or adopt health promoting behaviors

# Scope of work – Non-Traditional Health Workers

## 3. Case Management, Care Coordination, & System Navigation

Collaborative process of assessment, planning, facilitation and advocacy to help people evaluate options and access services in order to meet their holistic health needs through available resources in a timely, efficient and culturally appropriate manner

## 4. Health Promotion and Coaching

The process of enabling people to increase control over their health and its determinants, and thereby improve their health; includes assisting individuals and their identified families to make desired behavioral changes, identifying and enhancing strengths and addressing barriers

# Competencies & Training

Role	Competencies	Training
1. Outreach and Mobilization	<ul style="list-style-type: none"> <li>Communicate effectively with individuals and their identified families and community members about individual needs, concerns and assets</li> <li>Identify and document needs and health topics relevant to the priority population, including common strengths, barriers and challenges</li> <li>Adapt outreach strategies based on population, venue, behavior or identified risks as appropriate to a given population and its self-determined concerns</li> <li>Engage individuals and community members in ways that establish trust and rapport with them and their families</li> <li>Create a non-judgmental atmosphere in interactions with individuals and their identified families</li> <li>Develop and disseminate culturally and linguistically appropriate information to service population regarding available services and processes to engage in services</li> <li>Document and help create networks and establish partnerships and linkages with other NTHWs and organizations for the purpose of care coordination and enhancing resources</li> <li>Support individuals and their identified families and community members to utilize care and community resources</li> <li>Effectively utilize various education and communication strategies to inform and educate individuals and community members about health, health interventions, and available health services</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>Outreach Methods</li> <li>Community Engagement, Outreach and Relationship Building</li> <li>Communication Skills, including cross-cultural communication, active listening, and group and family dynamics</li> <li>Empowerment Techniques</li> <li>Knowledge of Community Resources</li> </ul> <p>Additional Required Curriculum for specific worker types, practice settings, or jobs:</p> <ul style="list-style-type: none"> <li>Self-Efficacy (Community Health Workers, Peer Wellness Specialists)</li> <li>Community Organizing (Community Health Workers)</li> <li>Group Facilitation Skills (Community Health Workers, Peer Wellness Specialists)</li> </ul>
2. Community and Cultural Liaising	<ul style="list-style-type: none"> <li>Advocate for individuals and their identified families, and community groups/populations</li> <li>Recognize and define cultural, linguistic, and social differences, such as differing understandings of: family unity, religious beliefs, health-related beliefs and practices, generational differences, traditions, histories, socioeconomic system, refugee and immigration status and government systems</li> <li>Educate service systems about community needs and perspectives</li> <li>Build individual and community capacity to support people who seek and receive care by providing information/education on specific health issues and interventions, including identifying and addressing social determinants of health</li> <li>Recognize conflict and utilize conflict resolution strategies</li> <li>Conduct individual needs assessments</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>Cultural Competency/Cross Cultural Relationships</li> <li>Conflict Identification and Problem Solving</li> <li>Social Determinants of Health</li> <li>Conducting individual Needs Assessments</li> <li>Advocacy Skills</li> <li>Building Partnerships with local agencies and groups</li> </ul> <p>Additional Required Curriculum for specific worker types, practice settings, or jobs:</p> <ul style="list-style-type: none"> <li>Conducting Community Needs Assessments (Community Health Workers)</li> </ul>
3. Case Management, Care Coordination and System Navigation	<ul style="list-style-type: none"> <li>Deliver person-centered advocacy</li> <li>Provide timely and accurate referrals</li> <li>Work effectively across multidisciplinary teams</li> <li>Demonstrate and communicate understanding of public and private health and human services systems</li> <li>Coordinate between multiple providers and systems providing care and services</li> <li>Assure follow up care and support individual and providers to maintain connections throughout treatment process</li> <li>Disseminate information to appropriate individuals</li> <li>Understand and maintain ethical boundaries between self and individual or family being served</li> <li>Describe individual(s)' rights and confidentiality clearly and appropriately, including informed consent and mandatory reporting requirements</li> <li>Utilize crisis management techniques</li> <li>Complete accurate and timely documentation of care processes, including effectively using tools such as computer programs, databases, charts and other documentation materials needed by supervisor/care team</li> <li>Assist individual (and identified family members as appropriate) to set goals and collaboratively plan specific actions to reach goals</li> <li>Assist people with paperwork needed to access services</li> <li>Assist people to access basic needs services (e.g. food, housing, employment, etc.)</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>The Role of Non-Traditional Health Workers</li> <li>Roles and Expectations for Working in Multidisciplinary Teams</li> <li>Ethical Responsibilities</li> <li>Legal Responsibilities</li> <li>Paths to Recovery (specific to worker type)</li> <li>Data Collection and Types of Data</li> <li>Organization Skills and Documentation</li> <li>Crisis Identification, Intervention and Problem-Solving</li> <li>Professional Conduct (including relationship boundaries and maintaining confidentiality)</li> <li>Navigating public and private health and human service systems (state, regional, local)</li> <li>Working with caregivers, families, and support systems, including paid care workers</li> </ul>
4. Health Promotion and Coaching	<ul style="list-style-type: none"> <li>Define and describe basic disease processes including chronic diseases, mental health, and addictions, basic warning signs and symptoms</li> <li>Define and describe basic dynamics of traumatic issues impacting health, such as child abuse, domestic violence, self harm, and suicide</li> <li>Motivate individual to engage in behavior change, access needed services and/or advocate for themselves</li> <li>Provide coaching and support for behavior change (self-management), including responding to questions and/or fears, offering multiple examples of desired changes and potential outcomes, and using appropriate and accessible formats for conveying health information</li> <li>Collect and apply knowledge of individuals' history and background, including experiences of trauma, to inform health promotion and coaching strategies</li> <li>Assist individual to set goals and collaboratively plan specific actions to reach goals</li> <li>Provide informal emotional or psychological support through active listening, paraphrasing and other supportive techniques</li> <li>Support and empower individuals to choose from treatment options where available and support adherence to treatment choice</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>Introduction to Disease Processes including chronic diseases, mental health, and addictions (warning signs, basic symptoms, when to seek medical help)</li> <li>Trauma-Informed Care (screening and assessment, recovery from trauma, minimizing re-traumatization)</li> <li>Health Across the Life Span</li> <li>Adult Learning Principles - Teaching and Coaching</li> <li>Stages of Change</li> <li>Health Promotion Best Practices</li> <li>Self-Care</li> <li>Health Literacy Issues</li> </ul> <p>Additional Required Curriculum for specific worker types, practice settings, or jobs:</p> <ul style="list-style-type: none"> <li>Popular Education Methods (Community Health Workers)</li> <li>Cultivating Individual Resilience (Peer Wellness Specialists)</li> <li>Recovery Model (Peer Wellness Specialists)</li> <li>Healthcare Best Practices (specific to fields of practice)</li> <li>Wellness within a specific disease (Personal Health Navigator)</li> <li>Basic health screenings (e.g. blood pressure measurement)</li> </ul>

# Certification – Non-Traditional Health Workers

## Goals of certification:

- Clarify NTHW role
- Facilitate optimal integration of NTHWs by health care providers
- Bolster sustainable funding options, including reimbursement through Medicaid and Medicare
- Promote recognition of the value of NTHWs
- Highlight options for individual development along health care career paths

## Certification must not:

- Exclude currently practicing NTHWs from their own field
- Create unreasonable barriers for new NTHWs to enter the field
- Discourage the use of holistic and culturally based approaches key to reducing health disparities and promoting health equity

# Certification – Non-Traditional Health Workers

Subcommittee recommends a two-part process:

1. Central body reviews and approves competency-based training programs
2. Programs provide individuals with certificate of completion; OHA requires that certification for enrollment as Medicaid provider

Training:

- Exact number of hours still under discussion (working recommendation is min. 80 didactic or on-the-job training, with additional hours for supplemental training specific to worker types, practice settings, or jobs)
- “Grandparent” currently practicing NTHWs who also participate in an incumbent worker training. Number of practice years required for "grandparenting" TBD; may differ by worker type due to length of time that job categories have been in existence
- Limit the cost of enrolling in training programs for NTHWs

# Certification – Non-Traditional Health Workers (2)

## Training Oversight:

- Establish or assign oversight for training programs to central body. This entity would:
  - Review and approve training programs and educational methodologies
  - Maintain a registry and/or certification records, including ethics violations
  - Promote NTHW professions, including educating health care providers and systems on the effective utilization of NTHWs
- Entity should convene an advisory body to provide T.A. and feedback to training programs to ensure continuous improvement and comparability of training for job mobility. The advisory body should include experienced NTHWs in numbers sufficient to maintain integrity of the NTHW model(s).
- Review and renew training programs every 3 years to ensure quality, relevance and compliance with curriculum requirements, educational standards, and expected performance outcomes for workers

# Certification – Non-Traditional Health Workers (3)

## Additional Recommendations:

- Require supervision of NTHWs by qualified health care professionals, behavioral health professionals, or Masters-level public health workers
- Provide incentives for CCOs to develop internal agency plans for the supervision and support of NTHWs, including developing strategies within the global budget to support training and retention of NTHWs on health care teams
- Develop strategies for all training partners to assess the needs of NTHWs for continuing education, to design and develop programs to meet those needs, and to implement and evaluate programs on an ongoing basis

## Competencies and Training Recommendations for NTHWs, by Role

Role	Competencies	Training
1. Outreach and Mobilization	<ul style="list-style-type: none"> <li>• Communicate effectively with individuals and their identified families and community members about individual needs, concerns and assets</li> <li>• Identify and document needs and health topics relevant to the priority population, including common strengths, barriers and challenges</li> <li>• Adapt outreach strategies based on population, venue, behavior or identified risks as appropriate to a given population and its self-determined concerns</li> <li>• Engage individuals and community members in ways that establish trust and rapport with them and their families</li> <li>• Create a non-judgmental atmosphere in interactions with individuals and their identified families</li> <li>• Develop and disseminate culturally and linguistically appropriate information to service population regarding available services and processes to engage in services</li> <li>• Document and help create networks and establish partnerships and linkages with other NTHWs and organizations for the purpose of care coordination, prevention or harm reduction, and enhancing resources</li> <li>• Support individuals and their identified families and community members to utilize care and community resources</li> <li>• Effectively utilize various education and communication strategies to inform and educate individuals and community members about health, health interventions, and available health supports and services</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>• Outreach Methods</li> <li>• Community Engagement, Outreach and Relationship Building</li> <li>• Communication Skills, including cross-cultural communication, active listening, and group and family dynamics</li> <li>• Empowerment Techniques</li> <li>• Knowledge of Community Resources</li> </ul> <p>Additional Required Curriculum for specific worker types, practice settings, or jobs:</p> <ul style="list-style-type: none"> <li>• Self-Efficacy (Community Health Workers, Peer Wellness Specialists)</li> <li>• Community Organizing (Community Health Workers)</li> <li>• Group Facilitation Skills (Community Health Workers, Peer Wellness Specialists)</li> </ul>
2. Community and Cultural Liaising	<ul style="list-style-type: none"> <li>• Advocate for individuals and their identified families, and community groups/populations</li> <li>• Recognize and define cultural, linguistic, and social differences, such as differing understandings of: family unity, religious beliefs, health-related beliefs and practices, generational differences, traditions, histories, socioeconomic system, refugee and immigration status and government systems</li> <li>• Educate care teams &amp; service systems about community needs and perspectives</li> <li>• Build individual, clinical team, and community capacity to support people who seek and receive care by providing information/education on specific health issues and interventions, including identifying and addressing social determinants of health</li> <li>• Recognize conflict and utilize conflict resolution strategies</li> <li>• Conduct individual needs assessments</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>• Cultural Competency/Cross Cultural Relationships, including bridging clinical and community cultures</li> <li>• Conflict Identification and Problem Solving</li> <li>• Social Determinants of Health</li> <li>• Conducting individual Needs Assessments</li> <li>• Advocacy Skills</li> <li>• Building Partnerships with local agencies and groups</li> </ul> <p>Additional Required Curriculum for specific worker types, practice settings, or jobs:</p> <ul style="list-style-type: none"> <li>• Conducting Community Needs Assessments (Community Health Workers)</li> </ul>
3. Case Management, Care Coordination and	<ul style="list-style-type: none"> <li>• Deliver person-centered information and advocacy</li> <li>• Provide timely and accurate referrals</li> <li>• Work effectively across multidisciplinary teams</li> <li>• Demonstrate and communicate understanding of public and private health and</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>• The Role of Non-Traditional Health Workers</li> <li>• Roles and Expectations for Working in Multidisciplinary Teams</li> <li>• Ethical Responsibilities in a multicultural context</li> </ul>

Role	Competencies	Training
System Navigation	<p>human services systems</p> <ul style="list-style-type: none"> <li>• Coordinate between providers, teams and systems providing care &amp; services</li> <li>• Assure follow up care and support individual and providers to maintain connections throughout treatment process</li> <li>• Disseminate information to appropriate individuals</li> <li>• Understand and maintain ethical boundaries between self and individual or family being served</li> <li>• Describe individual(s)' rights and confidentiality clearly and appropriately, including informed consent and mandatory reporting requirements</li> <li>• Utilize crisis management techniques</li> <li>• Complete accurate and timely documentation of care processes, including effectively using tools such as computer programs, databases, charts and other documentation materials needed by supervisor/care team</li> <li>• Assist individual (and identified family members as appropriate) to set goals and collaboratively plan specific actions to reach goals</li> <li>• Assist people with paperwork needed to access services</li> <li>• Assist people to access basic needs services (e.g. food, housing, employment, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>• Legal Responsibilities</li> <li>• Paths to Recovery (specific to worker type)</li> <li>• Data Collection and Types of Data</li> <li>• Organization Skills and Documentation, including use of HIT</li> <li>• Crisis Identification, Intervention and Problem-Solving</li> <li>• Professional Conduct (including culturally appropriate relationship boundaries and maintaining confidentiality)</li> <li>• Navigating public and private health and human service systems (state, regional, local)</li> <li>• Working with caregivers, families, and support systems, including paid care workers</li> </ul>
4. Health Promotion and Coaching	<ul style="list-style-type: none"> <li>• Define and describe basic disease processes including chronic diseases, mental health, and addictions, basic warning signs and symptoms</li> <li>• Define and describe basic dynamics of traumatic issues impacting health, such as historical and cultural trauma, child abuse, domestic violence, self harm, and suicide</li> <li>• Motivate individual to engage in behavior change, access needed services and/or advocate for themselves</li> <li>• Provide coaching and support for behavior change (self-management), including responding to questions and/or fears, offering multiple examples of desired changes and potential outcomes, and using appropriate and accessible formats for conveying health information</li> <li>• Collect and apply knowledge of individuals' history and background, including experiences of trauma, to inform health promotion and coaching strategies</li> <li>• Assist individual to set goals and collaboratively plan specific actions to reach goals</li> <li>• Provide informal emotional or psychological support through active listening, paraphrasing and other supportive techniques</li> <li>• Support and empower individuals to choose from treatment options where available and support adherence to treatment choice</li> </ul>	<p>Core Curriculum:</p> <ul style="list-style-type: none"> <li>• Introduction to Disease Processes including chronic diseases, mental health, and addictions (warning signs, basic symptoms, when to seek medical help)</li> <li>• Trauma-Informed Care (screening and assessment, recovery from trauma, minimizing re-traumatization)</li> <li>• Health Across the Life Span</li> <li>• Adult Learning Principles - Teaching and Coaching</li> <li>• Stages of Change</li> <li>• Health Promotion Best Practices</li> <li>• Self-Care</li> <li>• Health Literacy Issues</li> </ul> <p>Additional Required Curriculum for specific worker types, practice settings, or jobs:</p> <ul style="list-style-type: none"> <li>• Popular Education Methods (Community Health Workers)</li> <li>• Cultivating Individual Resilience (Peer Wellness Specialists)</li> <li>• Recovery Model (Peer Wellness Specialists)</li> <li>• Healthcare Best Practices (specific to fields of practice)</li> <li>• Wellness within a specific disease (Personal Health Navigator)</li> <li>• Basic health screenings (e.g. blood pressure measurement)</li> </ul>

**Improving Oregon's Health:  
Recommendations for Building a Healthcare Workforce for  
New Systems of Care**

**Brief Report from the Oregon Healthcare Workforce Committee to the  
Oregon Health Policy Board**

**DRAFT  
December 27, 2011**

## Table of Contents

### Executive Summary

I.	Introduction.....	1
II.	Background - new systems of care delivery .....	1
III.	Workforce competencies and models from national literature .....	2
	<i>Interprofessional competencies</i> .....	2
	<i>Communication competencies</i> .....	3
	<i>Computer literacy and health informational technology competencies</i> .....	4
	<i>Other professional competencies</i> .....	4
	<i>Transforming health professional education</i> .....	5
	<i>Transforming practice</i> .....	5
IV.	Workforce competencies and models from the Oregon perspective .....	6
	<i>Individual competencies</i> .....	6
	<i>Organizational competencies</i> .....	8
V.	Recommendations.....	10
	<i>Recommendations for policy</i> .....	10
	<i>Recommendations for education</i> .....	10
	<i>Recommendations for practice</i> .....	11
VI.	Conclusions and next steps .....	12

### References

### Appendices

Recommendations Table

List of Oregon experts consulted

Consultant interview guide

Qualitative analysis of consultant interviews

Report Authors and Workforce Committee members

## Executive Summary

In May 2011, the Oregon Health Policy Board requested that the Oregon Healthcare Workforce Committee identify and describe the workforce models and health care professional competencies best suited to support promising new systems of care delivery and to recommend strategies to encourage adoption of promising workforce models and development of the associated competencies among Oregon's workforce. To meet these goals, the Committee reviewed the existing literature and recommendations from national bodies. It also conducted interviews with over thirty healthcare professionals, educators, health system administrators, and policy experts, whose accomplishments in health care are known regionally and nationally as well as within the State of Oregon.

The Committee strongly endorses interprofessional and team-based care as optimal methods for patient-centered primary care homes and Coordinated Care Organizations to achieve the clinical and financial outcomes of the Triple Aim: comprehensive and coordinated whole-person care, improved efficiency and better patient health. Key competencies associated with this model include individual skills with collaborative practice, health information technology (HIT), and communication, as well as organization- or system-level capacities such as flexible reimbursement, operational and managerial supports, and community engagement.

The Committee's initial recommendations for fostering the adoption of interprofessional, team-based care and associated competencies in Oregon are in three categories: policy, education, and practice. The most important and urgent in each category are listed below; additional recommendations can be found in the body of the report:

- *Policy*: Establish and expand pilot programs to test alternative payment models that enable flexible use of the healthcare workforce (e.g. global budgets for Coordinated Care Organizations, bundled payments for acute and post-acute care, and salaried providers).
- *Education*: Set expectations for ongoing and sustainable collaboration between academic/training/education communities and health care employers, so that educational experiences will be more connected and interdependently functioning in providing health care services.
- *Practice*: Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices.

## **I. Introduction**

The Oregon Health Care Workforce Committee (Committee) was established in 2009 to develop recommendations and action plans for training, recruiting and retaining a health care workforce that can meet the needs of new systems of care delivery, as well as the demand for care in the next decade. In May 2011, the Oregon Health Policy Board charged the Committee to describe the workforce models and health care professional competencies needed to support promising new systems of care delivery, in particular patient-centered primary care homes and Coordinated Care Organizations. The Committee was also asked to recommend strategies to encourage adoption of promising workforce models and development of the associated professional competencies among Oregon's workforce. This brief report summarizes the Committee's analysis and recommendations.

## **II. Background – New Systems of Care Delivery**

Health reform initiatives in Oregon and the rest of the nation require changes in how health care is delivered and financed. The drive for reform is familiar to many: lack of coordination and integration among mental, physical, specialty, and other kinds of health care often results in frustration and poor outcomes for patients; fee-for-service reimbursement incents illness (“sick”) care rather than health maintenance or prevention; and health care costs are unsustainably high and increasing for families, employers, and government.

Governor Kitzhaber, the Oregon Legislature, Oregon's Health Policy Board and the Oregon Health Authority are working with partners on two closely related initiatives to reform care delivery in the public sector: patient-centered primary care homes and Coordinated Care Organizations, as described in HB 3650, known as the Health Care Transformation Initiative.

- Patient-centered primary care homes (PCPCHs) are being implemented across the country to achieve the “triple aim” of better health outcomes, improved patient experience, and reduced costs. PCPCHs achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with chronic conditions and other special health care needs, and a patient and family centered approach to all aspects of care. Oregon standards for PCPCHs were developed in 2010 and the Health Authority has just launched a process to recognize primary care homes and qualify them for enhanced reimbursement for Medicaid patients. The state aims to make patient-centered primary care homes available to 75% of Oregonians by 2015.
- Coordinated Care Organizations (CCOs) are intended to integrate physical (including hospital and specialty), behavioral, and oral health care for Oregon Health Plan members

and act as a single point of accountability for the health of the populations they serve. CCOs will be reimbursed for OHP services through global budgets designed to cover all types of care, allowing them the flexibility to allocate resources toward the care and provider types as best suits population needs. They will be held accountable for their performance on each aspect of the triple aim through quality measures and contracted performance standards, currently in development. PCPCHs will, in many cases, be central to the CCO's clinical delivery system.

Both of these models require healthcare professionals to work in new ways with each other and with patients. These realities raise critical questions of how many health workers of what kinds will be needed and what core competencies will be essential to make their work effective and efficient in the new systems of care.

### **III. Workforce Competencies and Models from National Literature**

In its 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the Institute of Medicine (IOM) stated the importance of preparing the health care workforce to make a smooth transition into a redesigned health care system. Among the recommendations related to health care workforce education was the need to teach evidence-based practice and provide opportunities for interdisciplinary training.

In follow up, the IOM (2003) convened a summit to identify a core set of competencies integral to providing safe, high quality and accessible health care. The core competencies include the ability to provide patient-centered care to diverse populations, work in interdisciplinary teams, employ evidence-based practice, apply quality improvement, and utilize informatics.

Since the publication of the IOM's report, additional efforts have further delineated health care workforce competencies, role adaptations, and changes in health profession education needed for new models of health care delivery.

#### *Interprofessional Competencies*

Eloranta (2009) observed that "the clinical environment has evolved beyond the limitations of individual human performance." Health care workforce shortages, a growing, aging and diverse population, greater numbers of people with chronic health conditions, and advances in medical science and technology combined with redesigned delivery systems have created an opportunity for health care professionals to engage in collaborative, interdisciplinary teams to improve access, quality and patient outcomes, and to increase their own job satisfaction.

This interprofessional team-approach to health has been defined as “a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health issues (Orchard, Curran, Kabene, 2005).” Experts have identified that transforming current practices to team-based care necessitates a change in health profession education; away from isolated pathways and traditional roles to an approach that facilitates collaboration, communication and coordination across professions and specialties. (Safety Net Medical Home Initiative, 2011; Bridges, Davidson, Odegard, Maki, Tomkowiak, 2011; Commission on Education of Health Professionals for the 21st Century, 2010; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Institute of Medicine Forum on the Future of Nursing: Education, 2010)

The Canadian Interprofessional Health Collaborative (2010) described six competency domains to prepare health care professionals and students for effective interprofessional collaboration: interprofessional communication; patient/client/family/community-centered care; role clarification; team functioning; collaborative leadership; and interprofessional conflict resolution.

The Interprofessional Education Collaborative (IPEC) convened an expert panel (2011a) to develop competencies for interprofessional practice. Four competency domains were identified: values and ethics for interprofessional practice; roles and responsibilities for care providers in a collaborative practice; effective interprofessional communication; and interprofessional teamwork and team-based care for shared problem solving and individual and team performance improvement. Based on these four competency domains, the IPEC, the Health Resources and Services Administration and philanthropic organizations convened a leadership conference to develop an action plan for incorporating these competencies into health profession education and health care delivery systems (2011b).

### *Communication Competencies*

Timmons and O’Leary (2004) reported that communication-related issues were the most frequently reported root cause of sentinel events between 1995 to 2003 in JCAHO-accredited health care organizations. The IPEC (2011a) identified that communication patterns and professional jargon used in current health practices create barriers to sharing professional expertise to improve patient care. Additionally, experience with interprofessional communication is often missing in health profession education (Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010).

New models of health care delivery require communication competencies that enable all interprofessional team members to voice concerns, use a common language for team communication, resolve interprofessional conflicts, use electronic health records effectively, and present information to patients and their families in ways that can be understood (IPEC, 2011a). Communication-related competencies and the effective use of communication tools and techniques have been identified as key to team development, building trust and a culture of patient safety, and improving patient outcomes, patient experiences, job satisfaction, and organizational learning and efficiencies (Bello, 2011; Blash, Dower & Chapman, 2011; IPEC, 2011a; Mauksch, 2011; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Eloranta, 2009; Suter, Arndt, Arthur, Parboosingh, Taylor & Duetschlander, 2009; Institute for Health Care Improvement, n.d.).

### *Computer Literacy and Health Information Technology Competencies*

Electronic health records are considered a crucial component of health reform efforts in improving systems of care, improving communication with patients and between providers, reducing costs through greater efficiencies, improving clinic workflow, and providing data to improve patient outcomes (Safety Net Medical Home Initiative, 2011; Hummel, 2010; OHWI, 2010; Shaller, 2007). To accomplish these goals, national and professional associations have recommended that health care professionals possess a basic set of computer, information literacy and information management competencies for the safe, effective and efficient use of electronic health records (Technology Informatics Guiding Education Reform Initiative, 2009; AHIMA & AMIA, 2005).

The Oregon Board of Nursing has recognized the role of electronic health records in patient care by including regulatory language in the Oregon Nurse Practice Act (OAR 851-045-004(4)(a-b), which requires nurses to have competencies in nursing informatics and related technologies.

### *Other Professional Competencies*

Additional workforce competencies associated with emerging health care delivery models include cultural competency (communication and other skills necessary to provide appropriate and effective care to individuals from different backgrounds) (Like, 2011; Jungnickel, Kelley, Hammer, Haines, Marlowe, 2009; Saha, Beach, Cooper, 2008), quality improvement skills (Safety Net Medical Home Initiative, 2011) leadership and change management skills (Institute of Medicine, 2011; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010) and proactive population-based care practices (Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Ginsburg, Maxfield, O'Malley, Peikes & Pham, 2008).

### *Transforming Health Professional Education*

Hackbarth and Boccuti (2011) advocated that the content of health profession education needs to match anticipated needs in order to develop an effective and sustainable health care system. Traditionally, health profession education programs establish curricula based on accreditation standards with new content added over time. This approach has disadvantages in a rapidly changing health care environment and limits opportunities for innovation. The Institute of Medicine's report on *The Future of Nursing: Leading Change, Advancing Health* (2011), stated, "The explosion of knowledge and decision-science technology also is changing the way health professionals access, process, and use information. No longer is rote memorization an option. There simply are not enough hours in the day or years in an undergraduate program to continue compressing all available information into the curriculum."

The Commission on Education of Health Professionals for the 21st Century (2010) found that health profession curricula reflect historical legacies that drive learning objectives. In contrast, learning objectives that drive curriculum allow for a competency-based approach and inquiry-based learning which promote critical thinking, problem-solving, leadership skills, professional responsibility and innovations in health care delivery (Commission on Education of Health Professionals for the 21st Century; 2010; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Jungnickel, Kelley, Hammer, Haines & Marlowe, 2009).

Many of Oregon's educational institutions are already moving toward interprofessional training. For example, Pacific University groups students from physical and occupational therapy, dental sciences, pharmacy, and physician assistant programs together to provide community-based services in Nicaragua, and the new OUS/OHSU Collaborative Life Science building to be built in Portland will include an interprofessional clinical simulation lab. Linn Benton Community College, Oregon State University, and Western University of Health Sciences' College of Osteopathic Medicine are partnering to offer an interprofessional education course to students of nursing, pharmacy, osteopathic medicine, dentistry, optometry, podiatry, veterinary medicine, and physician assistant students.

### *Transforming Practice*

Movement towards a patient-centric, collaborative, team-based care models necessitates enhanced roles for health care professionals and support staff who contribute to patients' health (Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010). Maximizing the potential of team-based care models by extending the roles of non-physician staff practicing at the full scope of their education and competency allows physicians the opportunity to focus their expertise on complex

cases, expands time to deliver evidence-based patient care, improves patient outcomes, improves job satisfaction, and may increase access and reduce costs of care (Blash, Dower & Chapman, 2011; Institute of Medicine, 2011; Safety Net Medical Home Initiative, 2011; Yarnall, Ostbye, Krause, Pollak, Gradison & Michener 2009; Laurant, Reeves, Hermens, Braspenning, Grol & Sibbald, 2004).

#### **IV. Workforce Competencies and Models from the Oregon Perspective**

To complement the review of existing literature and recommendations from national bodies, the Committee conducted interviews with over thirty healthcare professionals and educators across the state, including physicians, nurses, medical assistants, clinic administrators, health systems executives, educators, and policy experts, most of whom have direct experience with interprofessional practice, implementing new approaches to health care delivery, or training professionals to new competencies. These interviewees were asked:

- What staffing models and provider competencies are needed to improve care delivery and outcomes for patients?
- What changes should Oregon's health care educational system and practice environment adopt to support the spread of new staffing models and professional competencies, particularly interprofessional collaboration?
- What workforce strategies would be most effective for helping to achieve health equity?

The interviews were transcribed by staff and analyzed by Committee members collaborating with an independent qualitative analyst to identify themes, challenges, and recommendations. Details of the methods and independent analysis are in Appendix A; key findings follow.

##### *Individual Competencies*

Oregon experts affirmed the importance of a team-based care model and associated professional competencies. As illustrated in the quotes below, interviewees argued that team-based care enables the processes and outcomes that patient-centered primary care homes and Coordinated Care Organizations are intended to achieve: comprehensive, integrated, whole-person care, improved efficiency and better patient health.

**Healthcare Executive:** *“A strong primary care foundation is essential for an effective health care system...The Patient Centered Primary Care Home is now widely recognized as the model for strengthening primary care. It requires an interdisciplinary team.”*

**Physician:** *“A team-based model [is] focused on producing better outcomes for a defined population of patients. The MD doesn't necessarily need to see everyone.”*

**Healthcare Administrator:** “[We have] an RN on every team. They do chronic disease management. Nurses spend 60-70% of time proactively managing these patients over the phone, in person, through educational seminars or motivational interviewing, etc. This has really improved our diabetic and depression patient outcomes.”

Oregon experts echoed the national literature when identifying specific competencies needed for interprofessional, team-based care included. Skills and qualities mentioned in the interviews included: leadership, conflict resolution, interprofessional cultural competency (to understand and respect the roles and skills of other professionals), quality improvement, and communication. For example, interviewees suggested:

**Healthcare Administrator:** “They [doctors] also need to know how to manage conflict and how to assist a team in resolving conflict and staying on task (leading a team, but not giving orders and allocating tasks so much as guiding the members).”

**Medical Educator:** “We don’t train physicians to be effective team players - The whole interprofessional team needs training in communication.”

Most interviewees felt that healthcare providers are not acquiring these important competencies as a part of their regular education. Some also suggested that future professionals are not getting sufficient training in prevention, early intervention, population focused care, and chronic disease management.

**Healthcare Executive:** “This goes back to the training programs: training people in what it means to be a member of the team and how best to interact with other members. It’s a bit of a departure from traditional training with more of a focus on the sensitivity of how teams work.”

**Medical Assistant:** “[I don’t] think that medical assistants are being trained to do the current version of their job (in community colleges as well as in proprietary trainings) – [We are] missing teamwork and skills for primary care homes.”

However, many interviewees acknowledged that faculty and students have few opportunities too see these models and competencies in action:

**Physician:** “There’s a “train the trainer” concept involved here - Since the educators themselves don’t have a lot of experience with the model described above, they can’t really pass it on to their students.”

**Healthcare Executive:** “There are a lot of educational programs for teaching the correct team skills. The problem is more that students need to see those skills modeled in a work environment, not just taught in schools.”

A few participants noted that educational programs may find it difficult to incorporate new competencies into curriculums that are already very full or are constrained by national regulations (e.g. CMS restrictions on how much time medical residents must spend in hospitals) or accreditation standards.

Many consultants described similar roles to be filled on a primary care team, such as a primary care provider, a care coordinator and/or panel manager (depending on level), a medical assistant and a clerical assistant. However, several noted that there was no one-size fits all approach and that the ideal team is community-dependent:

**Physician:** “[Care] should be organized around the population, not around the providers. Then we need to figure out how to bring these people together and which competencies are necessary to meet the goals for a specific population.”

### *Organizational Competencies*

Oregon experts went somewhat beyond the national literature by identifying several practice- or system-level competencies necessary for the successful implementation of new systems of care. While some of these have corollaries with the individual professional skills described above, they pertain to the practice environment rather than to individual practitioners.

Interviewees argued that irrational and counterproductive reimbursement mechanisms must change in order to provide the workplace flexibility required for team-based care.

**Healthcare Administrator:** “The current reimbursement model doesn’t help for medical home or coordinated care organization-it becomes much less about the visit and much more about managing the population. If we keep paying for the visit, it’s not as effective in maintaining a healthy population.”

**Physician:** “Some organizations are more prepared than others, but are hamstrung by reimbursement models. The payment models are strong disincentives to reinforcing the primary care centric approach.”

Consultants also suggested that an egalitarian, collaborative workplace culture would be necessary for establishing effective teams:

**Medical Assistant:** “We need to get rid of the old hierarchy and implement a more equal, team-based system - all team members need to feel that they and their work are important and valued, as well as the specifics of their role on the team. Top-down decision-making contributes to this problem.”

**Healthcare Administrator:** “The highest performing teams that they have are those who have gotten over the traditional hierarchy and are respecting all team members.”

**Physician:** “It’s a hurdle to let the primary care physician out of the way and let the team take command. Providers have to learn not to be the boss and to work effectively in teams. This is more of a cultural issue.”

While individual practitioners need to know how to work within the team-based care model, organizations must have the technical infrastructure and operational capacity to support it.

**Physician:** “A good IT system is the glue that holds [coordinated care] together. [These models need] some form of regional health information organization (RHIO) system that allows patient records and other information to be widely and easily shared.”

**Physician:** “On a more practical level, we also need to figure out how to properly divide work, evaluate competencies, and determine optimum functionality of each team member. You need someone who’s developed a good model for this sort of teamwork, and [I haven’t] seen that before.”

**Healthcare Administrator:** “[We need to] get staff and clinics data on their population-their characteristics, needs, etc. This is a powerful motivator in beginning to brainstorm on how to address those needs.”

Oregon experts also mentioned community engagement as a key organizational competency both for building the appropriate workforce and advancing health equity.

**Physician:** “[Care] should be organized around the population, not around the providers. Then we need to figure out how to bring these people together and which competencies are necessary to meet the goals for a specific population.”

**Healthcare Administrator:** “It’s important to [me] that [my] staff represents the clients that they serve. [We] work with the schools to try to get a workforce that’s representative-then the staff themselves can be personal informants about the different cultures. Patients also become more comfortable this way.”

*Physician: “When the community runs the organization, then true health care equity happens.”*

Finally, a few interviewees cited uneven distribution of professionals by geography and provider type as a major impediment to the creation of effective interprofessional teams:

*Physician: “[We have a] high concentration of doctors in the metro area and dramatically fewer everywhere else. We need to invest in more “mid-level” providers—perhaps we even have too many doctors. So much of the medical world is standardized these days that, after the initial diagnosis, a PA could potentially take over.”*

## **V. Recommendations**

The overarching recommendation emerging from both national literature and conversations with local stakeholders is that Oregon must dramatically expand use of team-based, interprofessional care across the state. Development and dissemination of team-based care should be a priority on par with implementation of patient-centered primary care homes and Coordinated Care Organizations, since the success of those models depends in large part on highly competent provider teams. The Committee offers the following recommendations for achieving broad adoption of interprofessional, team-based care. Recommendations are presented separately for policy, education, and practice but several pertain to more than one sector. A table of these recommendations can be found in the Appendices.

### *Recommendations for Policy*

- Establish and expand pilot programs to test alternative payment models such as global budgets for Coordinated Care Organizations, bundled payments for acute and post-acute care, and salaried providers.  
(WHO: Policymakers, payers, and health systems)
- Develop job descriptions, scopes of work, competencies, and performance standards for “new” positions such as care coordinators, navigators, community health workers, etc.  
(WHO: Regulatory agencies and policy-makers, in cooperation with health care organizations/employers and educational entities. (A Subcommittee of the Oregon Healthcare Workforce Committee has undertaken this work and will report to the Health Policy Board in January.)
- Provide opportunities for multi-payer alignment around promising models of flexible, outcomes-focused reimbursement.  
(WHO: Policymakers and regulatory agencies)

- Revise job descriptions for existing categories of health care workers to reflect the nature of inter-professional, team-based care.  
(WHO: Regulatory agencies in cooperation with health care organizations/employers and educational entities)

### *Recommendations for Education*

Interprofessional training and competency-based curricula are not new ideas in education. But the current health care environment demands a much broader and more rapid implementation of these concepts than has been seen to date. Strategies for increasing the relevance of education for interprofessional, team-based care include the following:

- Set expectations for ongoing and sustainable collaboration between academic/training /education communities and health care employers, so that educational experiences will be more connected and interdependently functioning in providing health care services.  
(WHO: Educational institutions and health care industry employers)
- Collaborate across disciplinary boundaries to develop and implement the same set of interprofessional competencies.  
(WHO: educational institutions, regulatory agencies, accrediting bodies, and professional societies. One possibility would be to use a joint waiver or similar process to approach the relevant accrediting bodies.)
- Develop shared methods for training and assessment of interprofessional competencies.  
(WHO: Educational institutions, regulatory agencies, and professional societies)
- Provide opportunities for faculty—not just trainees—to gain experience with interprofessional practice and new models of care via “experience” sabbaticals that allow faculty to return to the field, utilizing staff from health care organizations that have adopted new models as adjunct faculty, or other means.  
(WHO: Educational institutions and health care industry employers)
- Increase opportunities for interprofessional training, especially in clinical settings. Emerging patient-centered primary care homes, CCOs, and other innovative service delivery organizations would be ideal settings for interprofessional teams of health profession students to learn about and contribute to new models of care.  
(WHO: Educational institutions and health care industry employers)

### *Recommendations for Practice*

- Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices. While culture change takes time, practices hosting students coming from interprofessional training programs can use those students as change agents to help accelerate the process.  
(WHO: Health system leaders and practicing professionals)
- Identify successful early adopters of team-based care models to assist practices with technology implementation and guideline development during the transition process.  
(WHO: Industry leaders and professional societies)
- Prioritize investment in the information technology infrastructure needed to support communication within and across teams and sites of care, and to enable providers to identify and proactively manage clusters of patients with particular needs.  
(WHO: Industry/health system leaders)
- Revise hiring and human resources practices to enable recruitment, retention, and evaluation of professionals engaged in interprofessional and team-based care.  
(WHO: Industry leaders and health care employers)

## **VI. Conclusions and Next Steps**

New models of health care delivery, including CCOs and patient-centered primary care homes hold great promise for improving health status, increasing care quality, and controlling health care costs. In order to deliver on this promise, Oregon needs a health care workforce that has the individual and organizational competencies necessary to work together in interprofessional teams. This brief report summarizes national and state-level expert thinking on the most important competencies and provides some initial recommendations for cultivating those competencies via action in the sectors of policy, education, and practice.

The Healthcare Workforce Committee suggests an online survey or similar process to collect feedback on these expert recommendations from a broad range of stakeholders, particularly practicing educators/trainers, health professionals, health care employers, system administrators, and consumers who may not be actively involved in policy conversations. The survey process should invite feedback on the substance of the report's recommendations as well as on the best steps and venues for implementing those recommendations. The Healthcare Workforce Committee would be pleased to undertake this additional data collection and feedback step at the request of the Health Policy Board.

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DRAFT



**The Role of Non-Traditional Health Workers in  
Oregon's Health Care System**

**Recommendations for Core Competencies and  
Education and Training Requirements for  
Community Health Workers, Peer Wellness Specialists and Personal Health  
Navigators**

**Developed by  
Oregon Health Policy Board  
Workforce Committee  
Non-Traditional Health Worker Subcommittee**

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# Table of Contents

<b>Executive Summary</b> .....	<b>1</b>
<b>I. Background</b> .....	<b>2</b>
<i>House Bill 3650</i> .....	2
<i>The Non-Traditional Health Worker (NTHW) Subcommittee</i> .....	3
<i>Process</i> .....	3
<i>Non-Traditional Health Worker Definitions</i> .....	3
<i>Evidence of Effectiveness of Service Delivery and Cost Savings</i> .....	4
<i>Community Health Workers</i> .....	4
<i>Peer Wellness Specialists</i> .....	5
<i>Personal Health Navigators</i> .....	6
<b>II. The Role of Non-Traditional Health Workers in Oregon</b> .....	<b>9</b>
<b>III. Recommendations</b> .....	<b>10</b>
<b>Roles, Competencies and Education and Training Requirements</b> .....	<b>10</b>
<i>Role 1: Outreach and Mobilization</i> .....	10
<i>Definition and Purpose</i> .....	10
<i>Competencies</i> .....	11
<i>Required Core Curriculum: Outreach and Mobilization</i> .....	11
<i>Additional Required Curriculum for specific worker types, practice settings or jobs</i> .....	11
<i>Role 2: Community and Cultural Liaising</i> .....	12
<i>Definition and Purpose</i> .....	12
<i>Competencies</i> .....	12
<i>Required Core Curriculum: Community and Cultural Liaising</i> .....	13
<i>Additional Required Curriculum for specific worker types, practice settings or jobs</i> .....	13
<i>Role 3: Case Management, Care Coordination, and System Navigation</i> .....	13
<i>Definition and Purpose</i> .....	13
<i>Competencies</i> .....	13
<i>Required Core Curriculum: Case Management, Care Coordination, and System Navigation</i> .....	14
<i>Role 4: Health Promotion and Coaching</i> .....	14
<i>Definition and Purpose</i> .....	14
<i>Competencies</i> .....	14
<i>Required Core Curriculum: Health Promotion and Coaching</i> .....	15
<i>Additional Required Curriculum for specific worker types, practice settings or jobs</i> .....	15

<b>Certification</b> .....	<b>16</b>
<i>Certification Concepts</i> .....	16
<i>Recommendations</i> .....	16
<b>IV. Endnotes</b> .....	<b>18</b>
<b>V. Appendices</b> .....	<b>20</b>
Appendix A: Non-Traditional Health Worker Subcommittee.....	20
Appendix B: Existing NTHW Certification Programs in Oregon .....	21
Appendix C: State Comparison of NTHW Certification.....	25
Appendix D: NTHW Survey.....	56

## Executive Summary

In 2011, the Oregon Legislature passed landmark legislation defining Oregon’s approach to health care reform. The Oregon Health Authority (OHA), under House Bill 3650, Section 13, established a public process to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. This system will deliver integrated health care and services to Oregonians through a Coordinated Care Organization (CCO) model of care, beginning with Oregon Health Plan enrollees and with special attention to coordinating care and services for Medicare beneficiaries who are also on the Oregon Health Plan.

Additionally, the legislation mandated the OHA, in consultation with the appropriate health professional regulatory boards and advocacy groups, to develop and establish with respect to community health workers, personal health navigators, peer wellness specialists and other health care workers who are not regulated or certified by the state of Oregon.

- (a) The criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and
- (b) Education and training requirements for such individuals.

For ease of documentation, the state grouped these workers under the title “non-traditional health workers.”

The Oregon Health Policy Board (OHPB) established and convened the Health Care Workforce Committee’s Non-Traditional Health Worker (NTHW) Subcommittee, staffed by the Office of Equity and Inclusion, in September 2011. Key to its success was the high level of expertise and diversity of representation on the Subcommittee.

The Non-Traditional Health Worker (NTHW) Subcommittee embarked on a process to develop recommendations on core competencies and education and training requirements for NTHWs, as well as to advise on additional concepts regarding the role of NTHWs. Briefly, the Subcommittee defined the scope of work under the following four roles:

1. Outreach and Mobilization
2. Community and Cultural Liaising
3. Case Management, Care Coordination and System Navigation
4. Health Promotion and Coaching

In addition to providing specific competencies and education and training recommendations for each of these roles, this report provides an overview of the national and Oregon-specific role of non-traditional health workers; evidence of the effectiveness of the service model, including cost savings; and a description of current practices and certification models in Oregon.

We acknowledge and sincerely thank the members of the NTHW Subcommittee for providing their diverse perspectives, expertise, and wise counsel in the development of these recommendations.

## I. Background

### House Bill 3650

In 2011, the Oregon Legislature passed landmark legislation defining Oregon's approach to health care reform. The Oregon Health Authority (OHA), under House Bill 3650, Section 13, established a public process to inform the development of an Oregon Integrated and Coordinated Health Care Delivery System. This system will deliver integrated health care and services to Oregonians through a Coordinated Care Organization (CCO) model of care, beginning with Oregon Health Plan enrollees and with special attention to coordinating care and services for Medicare beneficiaries who are also on the Oregon Health Plan.

The goal is a health care system where Coordinated Care Organizations (CCOs) are accountable for care management and providing integrated and coordinated health care for each organization's members. CCOs will be managed within fixed global budgets and will provide efficient, high quality, culturally competent care aimed at reducing medical cost inflation. Additionally, Oregon's health care system will maintain the regulatory controls necessary to ensure affordable, quality health care for all Oregonians by supporting the development of regional and community accountability for health and health care equity.

Oregon is experiencing a widespread shortage of its health care workforce and an increasingly diverse population. Building and fostering the role of the workforce of community health workers, peer wellness specialists, and personal health navigators by more fully integrating them into health care teams will help to assure high-quality, culturally competent care to traditionally underserved populations within an integrated and coordinated health care system. In addition, these "non-traditional health workers" are uniquely placed to work with community members to identify and resolve their own most pressing health issues by addressing the social determinants of health, thus contributing to reducing and eliminating health inequities.

Section 11 of HB 3650 directed the Oregon Health Authority, in consultation with the appropriate health professional regulatory boards and advocacy groups, to develop and establish with respect to community health workers, personal health navigators, peer wellness specialists and other health care workers who are not regulated or certified by the state of Oregon:

- (a) The criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and
- (b) Education and training requirements for such individuals.

The criteria and requirements *must be* broad enough to encompass the potential unique needs of any coordinated care organization and must meet requirements of the Centers for Medicare and Medicaid Services in order that their services are reimbursable under Medicaid.

As the policy-making and oversight body for OHA, the Oregon Health Policy Board (OHPB) established the Health Care Workforce Committee's Non-Traditional Health Worker (NTHW)

Subcommittee to provide recommendations to the Board that meet the direction of Section 11 of HB 3650. The Subcommittee is staffed by the Office for Equity and Inclusion within OHA.

The NTHW Subcommittee has been guided by House Bill 3650, the Board's 2010 report *Oregon's Action Plan for Health*, and by OHA's Triple Aim:

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

## **The NTHW Subcommittee**

### **Process**

The NTHW Subcommittee was convened by the Oregon Health Policy Board as a subcommittee of the OHPB Workforce Committee. Committee members were appointed to represent a broad spectrum of stakeholder organizations, including health systems, insurers, educational institutions, behavioral health and addictions recovery programs, community clinics, social service and advocacy organizations, and practicing non-traditional health workers from the field. A list of the Subcommittee members is provided in Appendix A.

The Subcommittee, convened in September 2011, met over a four-month period to develop their recommendations. The process included conducting a scan of state and national research, existing legislation, published recommendations, and programs currently utilizing NTHWs. The NTHW Subcommittee also disseminated a survey of currently practicing NTHWs in Oregon, resulting in 620 responses. Using this background research, the Subcommittee then identified commonalities and differences among the defined worker types which provided a basis for establishing a scope of work that crosses all worker types and the core competencies necessary to effectively fulfill that scope. From there, education and training requirement recommendations were developed to align with the competencies. Additionally, recommendations were provided for specialized training for specific worker types.

### **Non-Traditional Health Worker Definitions**

House Bill 3650 defines community health workers, peer wellness specialists and personal health navigators. For ease of translation, we have used “non-traditional health workers” to encompass all three worker types:

***Community Health Worker*** means an individual who promotes health or nutrition within the community in which the individual resides, by:

- a) Serving as a liaison between communities, individuals and coordinated care organizations;
- b) Providing health or nutrition guidance and social assistance to community residents;
- c) Enhancing community residents' ability to effectively communicate with health care providers;
- d) Providing culturally and linguistically appropriate health or nutrition education;
- e) Advocating for individual and community health;

- f) Conducting home visitations to monitor health needs and reinforce treatment regimens;
- g) Identifying and resolving issues that create barriers to care for specific individuals;
- h) Providing referral and follow-up services or otherwise coordinating health and social service options; and,
- i) Proactively identifying and enrolling eligible individuals in federal, state, local, private or nonprofit health and human services programs.

### ***Peer Wellness Specialists***

For peer workers providing services in the field of behavioral health and addictions recovery, the State currently provides a definition for Peer Support Specialists only. Peer Support Specialists are those who provide peer delivered services to an individual or family member with similar life experience, under the supervision of a qualified Clinical Supervisor. A Peer Support Specialist must complete an Addictions and Mental Health-approved training program and be:

- (a) A self-identified person currently or formerly receiving mental health services; or
- (b) A self-identified person in recovery from a substance use disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; or
- (c) A family member of an individual who is a current or former recipient of addictions or mental health services.

The terminology “*peer wellness specialist*” is defined by peer support specialists who seek to expand the role from services focused on behavioral health and addictions recovery to include physical health promotion, and disease prevention and intervention activities for individuals and their families who experience mental health and substance abuse challenges. Peer wellness specialists receive training focused specifically reducing the levels of co-morbidity and shortened lifespan that are endemic among persons with behavioral health issues, and be active participants on primary care health teams.

***Personal Health Navigator*** means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the person’s particular circumstances and in light of the patient’s needs, lifestyle, combination of conditions and desired outcomes.

### **Evidence of Effectiveness of Service Delivery and Cost Savings**

As trusted community members who also understand health issues and the health care system, NTHWs are uniquely positioned to work with communities to identify and address the underlying causes of health problems. Resolving persistent health inequities requires addressing these underlying causes. The need to address health inequities must also drive development of the NTHW model.

### ***Community Health Workers***

Many studies show that CHWs contribute to improved health outcomes and overall health system savings through their impact on:

- (1) Improved prevention and chronic disease management, which reduces costly inpatient and urgent care costs;

- (2) Cost-shifting, with increased utilization of lower cost health services; and
- (3) Indirect savings associated with reallocation of expenditures within the health care system, e.g., by appropriate team allocations within the patient centered medical home.<sup>i ii iii</sup>

The return on investment method has been used to assess the contribution of CHWs to a reduction in Medicaid charges or health system total costs. CHW programs for which the return on investment has been calculated fall in the range of savings or returns of \$2.28 to \$4.80 for every dollar spent on CHWs.<sup>iv</sup> For example, CHWs working with underserved men in the Denver Health system were able to shift the costs of care from costly inpatient and urgent care to primary care, achieving a \$2.28 return on investment for every \$1.00 spent and an annual savings of \$95,941.<sup>vii</sup>

Several studies have documented the reduction in emergency care or inpatient services associated with a CHW intervention, with savings ranging from \$1,200 to \$9,300 per participant in programs with CHWs.<sup>viii ix x xi xii xiii</sup> In Baltimore, African-American Medicaid patients with diabetes who participated in a CHW intervention had a 40% decrease in emergency room (ER) visits, a 33% decrease in ER admissions, a 33% decrease in total hospital admissions, and a 27% decrease in Medicaid reimbursements. The CHW program produced an average savings of \$2,245 per patient per year and a total savings of \$262,080 for 117 patients.<sup>xiv</sup>

In New York, New York-Presbyterian Hospital (NYP) has been using CHWs in their childhood asthma program. Over a 12-month period of care coordination, CHWs reduced asthma-related ER visits and hospitalization rates by more than 50%. Hospital lengths of stay were also reduced. Based on these findings, NYP incorporated the costs of CHWs into their operating budget and CHWs are now a permanent part of the community-hospital partnership childhood asthma program.<sup>xv</sup>

The scope of CHW work typically includes a social justice and community organizing component. A variety of studies have suggested that CHWs' role as agents of social change is, in fact, their most important role (Eng & Young, 1992; Farquhar et al., 2008), and that "the true 'value-added' in the CHW model comes when [CHWs] are allowed and encouraged" to play this role (Wiggins and Borb'on, 1998, p. 45)<sup>xvi</sup>

### ***Peer Wellness Specialists***

There is ample evidence that a gap exists in the quality of services available for people with mental illnesses.<sup>xvii</sup> This is intricately linked to the overall quality of health services, and the failure to coordinate care across the spectrum of general and mental health care.<sup>xviii</sup> A research base has been established that demonstrates that peer-delivered services are an effective component of mental health care<sup>xix</sup> and that as part of a treatment team have been shown to have a range of favorable results in regards to both patient health outcomes and cost savings.<sup>xx</sup> Studies show:

- (1) When peers are part of hospital-based care, the results indicate shortened lengths of stays, decreased frequency of admissions, and a subsequent reduction in overall treatment costs<sup>xxi</sup>
- (2) Other studies also suggest that the use of peer support can help improve treatment adherence<sup>xxii</sup> and reduce the overall need and use for mental health services over time<sup>xxiii xxiv</sup>

## **Decrease in Hospitalization**

Several studies have documented the reduction of days spent in inpatient hospitalization for consumers with serious and persistent mental illness. Peerlink, a peer support initiative in Tennessee and Wisconsin, was able to decrease the number of hospitalization days for program participants from 7.42 to 1.9, a decrease of 73.32 percent in Tennessee. In Wisconsin, the average number of days per month of hospitalization for PeerLink participants was 0.86 or less than a day, according to the report. After involvement in the pilot program, the number of days dropped to 0.48 or by 44.19 percent.

## **Cost Savings**

In 2006, the Georgia Department of Behavioral Health and Developmental Disabilities compared consumers using certified peer specialists as a part of their treatment, versus consumers who received the normal services in day treatment. Consumers using the services of certified peer specialists showed improvement as compared to the control group in each three outcomes over an average of 260 days between assessments in all three areas:

- Reduction of current symptoms/behaviors
- Increase in skills/abilities
- Ability to access resources/ and meet their own needs

In comparing the costs of services, those using the certified peer specialists cost the state \$997 per year on average, compared to the average cost of \$6,491 in day treatment, a difference of \$5,494 per person.<sup>xxv</sup>

## **Increased Treatment Adherence and Overall Improved Health and Mental Health Outcomes**

In studies of persons dually diagnosed with serious mental illness and substance abuse, peer led interventions were found to significantly reduce substance abuse, mental illness symptoms, and crisis.<sup>xxvi</sup> Consumers participating in peer programs had better adherence to medication regimens<sup>xxvii</sup> had better healing outcomes, greater levels of empowerment, shorter hospital stays and fewer hospital admissions (which resulted in lower costs than control group).<sup>xxviii</sup>

Dr. John Rush, primary researcher on the NIMH STAR\*D depression study -the largest and most comprehensive study ever done in depression, conducted an evaluation of over 1,000 members participating in peer run programs through the Depression and Bipolar Support Alliance (DBSA). Ninety-five percent of those surveyed described their participation as helping them better communicate with their doctor, 97% of those surveyed described their groups as helping with being motivated to follow instructions, and being willing to take medication and cope with side effects. Those who had been participating for more than a year were less likely to have been hospitalized in the same period.<sup>xxix</sup>

Those who participate in peer delivered services build larger social support networks<sup>xxx</sup> and end up with enhanced self-esteem and social functioning.<sup>xxxi</sup> Peer delivered service participants showed greater levels of independence, empowerment and self- esteem. Over 60% indicated increased development of social supports.<sup>xxxii</sup>

## ***Personal Health Navigators***

Many studies show Personal Health Navigators contribute to improved health outcomes and overall

health system savings through their impact on:

- Quality of care, patient experiences, care coordination, and access<sup>xxxiii</sup>.
- Reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs. These savings at a minimum offset the new investments in primary care in a cost-neutral manner, and in many cases appear to produce a reduction in total costs per patient.<sup>xxxiv</sup>

In Pennsylvania, The Geisinger Health System, a large integrated delivery system in Pennsylvania, implemented a Patient Centered Medical Home redesign in 11 of its primary care practices beginning in 2007. Their Proven Health Navigator model focuses on Medicare beneficiaries, emphasizing primary care-based care coordination with team models featuring nurse care coordinators, electronic health record decision support, and performance incentives. Program evaluations show:

- **Better quality care:** Statistically significant improvements in quality of preventive (74.0% improvement), coronary artery disease (22.0%) and diabetes care (34.5%) for Patient-Centered Medical Home (PCMH) pilot practice sites.
- **Reduction in costs:** Statistically significant 14% reduction in total hospital admissions relative to controls, and a trend towards a 9% reduction in total medical costs at 24 months. Geisinger estimates a \$3.7 million net savings, for a return on investment of greater than 2 to 1.

In Michigan, The Genesee Health developed a PCMH model for its health plan serving 25,000 uninsured adults. The Genesee PCMH model, called Genesys HealthWorks, invested in a team approach to improve health and reduce costs, including a Health Navigator to work with primary care clinicians to support individuals to adopt healthy behaviors, improve chronic and preventive care, and provide links to community resources. Evaluations show:

- **Improved access:** 72% of the uninsured adults in Genesee County now identify a primary care practice as their medical home
- **Better quality:** 137% increase in mammography screening rates; 36% reduction in smoking and improvements in other healthy behaviors
- **Reduction in ER and inpatient costs:** 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6 % lower than competitors.

The following research matrix summarizes published studies of selected measures and costs savings, related to specific health issues impacts.

<b>Study</b>	<b>Health Issue</b>	<b>Outcome Measures</b>	<b>Cost Measures / Cost Savings</b>
Barnes-Boyd, (2001)	Infant mortality reduction	Mortality rates, program retention, health problems identified, immunization rates	Implied cost saving potential in that outcomes with nurse-CHW team at least equal to those of nurse-only team (no calculations)
Beckham, (2004)	Asthma management	Reported symptoms, doctor visits, ED visits	Total per capita costs reduced from \$310 to \$129; ED costs reduced from \$1,119 per participant to \$188
Fedder, (2003)	Diabetes management	ED visits, hospital admissions, quality-of-life indicators	Cost to Medicaid reduced an average of \$2,245 per patient per year; 27% decrease in mean expenditure
Krieger, (2005)	Asthma (indoor triggers)	Caregiver quality of life; use of urgent health services; symptom days	Urgent care costs were \$6,301 to \$8,856 less in the comprehensive CHW services group than the minimal CHW intervention group; Estimated decrease in costs over 2-mo period within comprehensive CHW services group was \$201 to \$334 per child
Liebman, (2007) & unpub. prog. data	Diabetes self-management	Glycemic control – changes in HbA1c levels	Annual self-management program cost: \$398,870; Annual cost per patient: \$532; Annual program ROI per patient = \$318 or 60%; For 165 clients in program, \$140,250 reduced costs in 1 year
May, (2007) & unpub. prog. data	Chronic disease	CHW care management program participants' visits to ER, & rates of hospitalization	Average annual cost for care among program participants decreased by \$10,000 or 58%; Over a three year period, the ROI for each dollar invested in the program is \$3.84
Rodewald, (1999)	Childhood immunizations	Immunization rates	Marginal cost per additional immunization administered = \$474. Each \$1,000 in program costs also produced additional preventive and other primary care office visits
Sox, (1999)	Cancer screenings for women	Effectiveness of trained Community Health Aides performing clinical exams and Pap smears (Alaska)	Implied cost saving in reduced travel of clinical personnel to remote villages (no calculations)

Weber, (1997)	Mammography	Rates of mammography use	Marginal cost of CHW activity per additional mammography performed = \$375, equivalent to \$11,591 per year of life saved
Whitley, (2006)	Primary care utilization	Utilization, charges and reimbursements	Care shifted from costly inpatient and urgent care services (\$16,872/visit and \$934/visit, respectively) to less costly primary care services (\$237/visit) – resulted in total decrease in charges of \$300,000 over study period; Average service cost savings per month = \$14,224; ROI for each dollar invested in the program is \$2.28, which equals \$95,941 saved/year

Adapted from: <http://www.mnchwalliance.org/> and Anthony, S., Gowler, R., Hirsch, G., & Wilkinson, G. (2009). Community Health Workers in Massachusetts: Improving health care and public health. Report of the Massachusetts Department of Public Health Community Health Worker Advisory Council

## II. The Role of Non-Traditional Health Workers in Oregon

Oregon has a rich history of groundbreaking NTHW programs. The Indian Health Service in Oregon has employed CHWs since the 1960s. The El Niño Sano Program in Hood River was one of a few seminal programs founded in migrant and seasonal farmworker communities in the late 1980s. During the 1990s, Neighborhood Health Clinics, Inc. employed African American CHWs in Portland. Other programs like the Parish Health Promoter Program of Providence/El Programa Hispano and a series of CHW programs at the Benton County Health Department have continued the Oregon tradition of innovation in the CHW field. The Community Capacitation Center (CCC) of the Multnomah County Health Department is a local expert on the CHW model. The CCC's training curriculum for CHWs is based on the findings of the National Community Health Advisor Study (NCHAS) and has been approved for academic credit by the Oregon State Board of Education. The CCC training program employs the adult education and popular education approach, involves CHWs in training other CHWs, and stresses empowerment as an important aspect of the training process.<sup>xxxv</sup>

The OHA Addictions and Mental Health Division (AMH) works with service population stakeholder groups to develop strategies to increase the use and availability of peer delivered services (PDS). AMH recognizes the indisputable value of PDS in transforming the mental health and addiction service delivery system that is based on a recovery model. Seventeen training programs are providing certification training for peer support and peer wellness specialists. Additionally, the Peer Wellness Program of Benton County Health Services began to develop a wellness-informed training program for both Peer Wellness Specialists and Peer Wellness Coaches. They developed an outcome measurement tool that informs their interventions with individuals being served. This work has been expanded upon

and enhanced by Cascadia Behavioral Health in Portland, where peer wellness specialists are trained to work with primary care community intervention teams, addressing the needs in the community of individuals who frequently use the in-patient and emergency department and other intensive health services. Program leaders anticipate significant cost savings, as well as enhanced quality of life for those serviced.

Appendix B provides a sample listing of NTHW training and certification programs in Oregon.

### **Home Care Workers as Non-Traditional Health Workers**

Nationally, it is estimated that the health care workforce includes 2.5 million home care and personal assistance workers, and that this number is expected to increase at rates four to five times that of jobs overall in the economy. The tremendous growth of this workforce is being fueled by profound structural changes in our society that are fundamentally reshaping long-term services and supports, including life expectancy increases and medical advances that allow individuals with chronic conditions and severe disabilities to live longer.<sup>xxxvi</sup>

In Oregon, the home care workforce is expected to grow by 23% between 2008 and 2018.<sup>xxxvii</sup> Home care and personal assistance workers provide essential daily supports and services to millions of Americans living with functional limitations and needs due to aging-related impairments, chronic disease, and other disabilities.<sup>xxxviii</sup> Based on the NTHW Survey, the Home Care Worker scope of work, competencies and training are closely aligned with that of the NTHWs defined in legislation. Home care workers who meet the competencies and education and training requirements of NTHWs described below will be an important addition to the Non-Traditional workforce.

## **III. Recommendations**

### **Roles, Competencies and Education and Training Requirements**

#### **Role 1: Outreach and Mobilization**

**Definition:** Outreach is the provision of health-related information, including information about health conditions, resources, and services to community members. Mobilization is working with individuals and their natural support systems to assure that community members who may be underserved or less likely to access health care services (because of barriers such as lack of health insurance, limited English proficiency [LEP], lack of information about available services, or social or physical isolation, such as for seniors and people with disabilities) are informed, served and motivated to take action on an individual, family or community level.

**Purpose:** The purpose of outreach and mobilization is to support individuals, their identified families, and community members to gain the information and skills needed to effectively engage in healthy behaviors and in the health systems that support them. Non-traditional Health Workers (NTHWs) use outreach and mobilization strategies and methods to connect community members and individuals with

existing supports and services and to bring services to where people reside and work, and at trusted community sites frequented by community members and individuals potentially in need of services.

**Competencies:** Demonstration of basic outreach and mobilization skills includes the ability to:

- Communicate effectively with individuals and their identified families and community members about individual needs, concerns and assets
- Identify and document needs and health topics relevant to the priority population, including common strengths, barriers and challenges
- Adapt outreach strategies based on population, venue, behavior or identified risks as appropriate to a given population and its self-determined concerns
- Engage individuals and community members in ways that establish trust and rapport with them and their families
- Create a non-judgmental atmosphere in interactions with individuals and their identified families
- Develop and disseminate culturally and linguistically appropriate information to service population regarding available services and processes to engage in services
- Document and help create networks and establish partnerships and linkages with other NTHWs and organizations for the purpose of care coordination, prevention or harm reduction, and enhancing resources
- Support individuals and their identified families and community members to utilize care and community resources
- Effectively utilize various education and communication strategies to inform and educate individuals and community members about health, health interventions, and available health supports and services

**Required Core Curriculum: Outreach and Mobilization**

- Outreach Methods
- Community Engagement, Outreach and Relationship Building
- Communication Skills, including cross-cultural communication, active listening, and group and family dynamics
- Empowerment Techniques
- Knowledge of Community Resources

**Additional Required Curriculum for specific worker types, practice settings, or jobs:**

- Self-Efficacy (Community Health Workers, Peer Wellness Specialists)
- Community Organizing (Community Health Workers)
- Group Facilitation Skills (Community Health Workers, Peer Wellness Specialists)

## **Role 2: Community and Cultural Liaising**

**Definition:** Community and Cultural Liaising means creating and supporting connections among individuals and their identified families, community members, providers, health systems, community based organizations and leaders, within a context of cultural beliefs, behaviors, and needs presented by individuals, their families and communities.

**Purpose:** To identify and effectively bridge cultural, linguistic, geographic and structural differences which prevent or limit individuals' ability to access health care or adopt health promoting or harm-reducing behaviors.

- Workers must be familiar with and maintain contact with agencies and professionals in the community in order to secure needed care and to build a network of community and professional support for the individuals they serve. They should participate in community, agency, and person-driven health planning and evaluation efforts that are aimed at improving care and bringing needed services into the community. Workers should bring information about individuals' lives that will help the provider team develop relevant health promotion and disease management strategies.
- When encountering linguistic differences, it is recommended that providers use only qualified and/or certified health care interpreters rather than engaging family members or informal interpreters. This does not preclude NTHWs who are also qualified or certified health care interpreters.
- Workers should understand the impact of social determinants of health on health outcomes and be prepared to include strategies that work to improve health outcomes by assisting providers in identifying culturally, linguistically, and community appropriate steps that reduce or remove barriers that may be uniquely impacting health outcomes in a given community.

**Competencies:** Demonstration of basic community and cultural liaison skills includes the ability to:

- Advocate for individuals and their identified families, and community groups/populations
- Recognize and define cultural, linguistic, and social differences, such as differing understandings of: family unity, religious beliefs, health-related beliefs and practices, generational differences, traditions, histories, socioeconomic system, refugee and immigration status and government systems
- Educate person-centered care teams and service systems about community needs and perspectives
- Build individual, clinical team, and community capacity to support people who seek and receive care by providing information/education on specific health issues and interventions, including identifying and addressing social determinants of health
- Recognize conflict and utilize conflict resolution strategies

- Conduct individual needs assessments

### **Required Core Curriculum: Community and Cultural Liaison**

- Cultural Competency/Cross Cultural Relationships (including bridging clinical and community cultures)
- Conflict Identification and Problem Solving
- Social Determinants of Health
- Conducting individual Needs Assessments
- Advocacy Skills
- Building Partnerships with local agencies and groups

### **Additional Required Curriculum for specific worker types, practice settings, or jobs:**

- Conducting Community Needs Assessments (Community Health Workers)

### **Role 3: Case Management, Care Coordination, and System Navigation**

**Definition:** Case management, care coordination and system navigation is a collaborative process of assessment, planning, facilitation and advocacy to help people evaluate options and access services.

**Purpose:** To meet an individual's holistic health needs through available resources in a timely and efficient manner, which may include recognizing and promoting system-level changes needed to meet individual and community needs. To assure the provision of culturally and linguistically appropriate services. To reduce duplicative, damaging or unnecessarily costly interventions that occur through lack of coordination.

**Competencies:** Demonstration of basic case management, care coordination and system navigation skills includes the ability to:

- Deliver person-centered information and advocacy
- Provide timely and accurate referrals
- Work effectively across multidisciplinary teams
- Demonstrate and communicate understanding of public and private health and human services systems
- Coordinate between multiple providers, provider teams, and systems providing care and services
- Assure follow up care and support individual and providers to maintain connections throughout treatment process
- Disseminate information to appropriate individuals
- Understand and maintain culturally-appropriate ethical boundaries between self and individual or family being served
- Describe individual(s)' rights and confidentiality clearly and appropriately, including informed consent and mandatory reporting requirements

- Utilize crisis management techniques
- Complete accurate and timely documentation of care processes, including effectively using tools such as computer programs, databases, charts and other documentation materials needed by supervisor/care team
- Assist individual (and identified family members as appropriate) to set goals and collaboratively plan specific actions to reach goals
- Assist people with paperwork needed to access services
- Assist people to access basic needs services (e.g. food, housing, employment, etc.)

### **Required Core Curriculum: Case Management, Care Coordination, and System Navigation**

- The Role of Non-Traditional Health Workers
- Roles and Expectations for Working in Multidisciplinary Teams
- Ethical Responsibilities in a Multicultural Context
- Legal Responsibilities
- Paths to Recovery (specific to worker type)
- Data Collection and Types of Data
- Organization Skills and Documentation, Using Health Information Technology
- Crisis Identification, Intervention and Problem-Solving
- Professional Conduct (including culturally-appropriate relationship boundaries and maintaining confidentiality)
- Navigating public and private health and human service systems (state, regional, local)
- Working with caregivers, families, and support systems, including paid care workers

### **Role 4: Health Promotion and Coaching**

**Definition:** Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health (World Health Organization, 2005).

**Purpose:** To assist individuals and their identified families in making desired behavioral changes and adopt behaviors that are sustainable, mutually acceptable, promote positive health outcomes, and are understood by families and community contacts. To identify and enhance individual, family, community, and social norms and strengths, as well as barriers to health and healthy behaviors.

**Competencies:** Demonstration of basic health promotion and coaching skills includes the ability to:

- Define and describe basic disease processes including chronic diseases, mental health, and addictions, basic warning signs and symptoms
- Define and describe basic dynamics of traumatic issues impacting health, such as child abuse, domestic violence, self harm, and suicide

- Motivate individual to engage in behavior change, access needed services and/or advocate for themselves
- Provide coaching and support for behavior change (self-management), including responding to questions and/or fears, offering multiple examples of desired changes and potential outcomes, and using appropriate and accessible formats for conveying health information
- Collect and apply knowledge of individuals' history and background, including experiences of trauma, to inform health promotion and coaching strategies
- Assist individual to set goals and collaboratively plan specific actions to reach goals
- Provide informal emotional or psychological support through active listening, paraphrasing and other supportive techniques
- Support and empower individuals to choose from treatment options where available and support adherence to treatment choice

**Required Core Curriculum: Health Promotion and Coaching**

- Introduction to Disease Processes including chronic diseases, mental health, and addictions (warning signs, basic symptoms, when to seek medical help)
- Trauma-Informed Care (screening and assessment, recovery from trauma, minimizing re-traumatization)
- Health Across the Life Span
- Adult Learning Principles - Teaching and Coaching
- Stages of Change
- Health Promotion Best Practices
- Self-Care
- Health Literacy Issues

**Additional Required Curriculum for specific worker types, practice settings, or jobs:**

- Popular Education Methods (Community Health Workers)
- Basic Healthcare Tasks associated with observation and reporting (Community Health Workers)
- Cultivating Individual Resilience (Peer Wellness Specialists)
- Recovery and Wellness Models (Peer Wellness Specialists)
- Healthcare Best Practices (specific to fields of practice)
- Healthcare Best Practices (specific to fields of practice as to be determined by CCO)

The Subcommittee also recommends advanced level training in Motivational Interviewing for Community Health Workers and Peer Wellness Specialists.

## **Certification**

### **Certification Concepts**

While many Oregon entities have developed strong programs to train and, in some cases, certify non-traditional health workers, no standard core curriculum for all NTHWs has been identified. This lack of standardization creates potential challenges for the field including:

- Lack of clarity of NTHW role
- Lack of optimal integration of NTHWs by health care providers
- Lack of sustainable funding, including missed opportunities for payment options through Medicaid/Medicare
- Limited recognition of the value of NTHWs
- Limited options for individual development along health care career paths

Key to others states' certification processes is the intentional minimization of requirements that could create unintended consequences, including:

- Loss of holistic and culturally based approaches key to reducing health disparities and promoting health equity
- Exclusion of community members and currently practicing NTHWs from their own field
- Creation of barriers for new NTHWs to enter the field

### **Recommendations**

In order to reduce barriers and unintended consequences through certification, the NTHW Subcommittee provides the following recommendations:

- Certify training programs that include the required core competencies and core curriculum. Exact number of hours and method of training are still under discussion by the Subcommittee; however, a minimum 80 core curriculum contact hours are currently recommended and both didactic and on-the job hours are under consideration, with additional contact hours adequate to cover the supplemental training recommended for specific worker types, practice settings, or jobs.
- Require statewide oversight of training programs through a yet to be determined mechanism, review and approve curriculum, review program educational methodologies to ensure inclusion of accepted adult learning strategies for high quality training, maintain registry and/or certification records, including potential ethics violations, advocate for and promote NTHW professions, including the provision of training for health care providers and systems on the effective utilization of NTHWs.
- Develop statewide training advisory panel to provide guidance and support to statewide entity given responsibility for training oversight to ensure that appropriate technical assistance, guidance and feedback can be provided to ensure that uniform statewide standards for training

programs produce trained individuals who can easily move between organizations and carry certification of standardized competencies, knowledge and skills to work in any CCO across the state. This training advisory panel should include experienced NTHWs in large enough numbers to ensure that the integrity of the model is retained and supported.

- Develop strategies for all training partners to assess the needs of NTHWs for continuing education, to design and develop programs to meet those needs, and to implement and evaluate programs on an ongoing basis.
- Provide individuals completing the approved training program with a certificate of completion. The certification is required to enroll as a provider for reimbursement.
- Limit the cost of enrolling in training programs for NTHWs.
- “Grandparent” NTHWs who also participate in an “incumbent worker” training. Specific "grandparenting" provisions for number of practice years in the field are to be determined, with the acknowledgment that there may need to be differences based on the worker type due to length of time that the job category has been in existence. Incumbent worker training curricula are to be determined by the statewide entity in collaboration with the advisory group to ensure that NTHWs that were trained in the past have a clear understanding of the Oregon roles, competencies and can demonstrate skills to perform at the level required in the set forth standards.
- Review and renew NTHW certificate programs every three years to assure quality, relevance and compliance in meeting curriculum requirements, teaching standards and performance outcomes.
- Provide incentives for Coordinated Care Organizations to develop internal agency plans for the supervision and support of NTHWs, including developing strategies within the global budget to support training development, career pathways, and retention of NTHWs on health care teams. Require supervision of NTHWs by licensed health care professionals, licensed behavioral health professionals, and Masters level public health workers.

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# **Coordinated Care Organization Implementation Proposal**

**House Bill 3650  
Health Care Transformation  
January 10, 2012**



## Oregon Health Policy Board

The nine-member Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for the Oregon Health Authority. The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health. Board members are nominated by the Governor and must be confirmed by the Senate. Board members serve a four-year term of office.

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## Table of Contents

<b>1. Executive Summary .....</b>	<b>1</b>
<b>2. Existing Market Environment and Industry Analysis.....</b>	<b>5</b>
<i>Target Population.....</i>	<i>5</i>
<i>Current Delivery System for Target Population.....</i>	<i>6</i>
<i>Population Characteristics and Health Status.....</i>	<i>7</i>
<i>Unsustainable Cost Growth.....</i>	<i>11</i>
<b>3. Opportunities for Achieving the Triple Aim: Improving Health, Improving Health Care and Reducing Cost.....</b>	<b>12</b>
<i>Health Management Associates Estimates of Health Transformation Savings.....</i>	<i>12</i>
<b>4. Coordinated Care Organization (CCO) Certification Process.....</b>	<b>15</b>
<i>Alternative Dispute Resolution.....</i>	<i>15</i>
<b>5. Coordinated Care Organization (CCO) Criteria.....</b>	<b>17</b>
<i>Governance and organizational relationships.....</i>	<i>17</i>
<i>Patient Rights and Responsibilities, Engagement, and Choice.....</i>	<i>19</i>
<i>Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements.....</i>	<i>21</i>
<i>Health Equity and Eliminating Health Disparities.....</i>	<i>25</i>
<i>Payment Methodologies that Support the Triple Aim.....</i>	<i>26</i>
<i>Health Information Technology.....</i>	<i>27</i>
<b>6. Global Budget Methodology.....</b>	<b>29</b>
<i>Primary Components of the CCO global budgets and shared accountability arrangements.....</i>	<i>29</i>
<i>Populations Included in Global Budget Calculations.....</i>	<i>30</i>
<i>Service/Program Inclusion and Alignment.....</i>	<i>30</i>
<i>Global Budget Development.....</i>	<i>31</i>
<b>7. Accountability.....</b>	<b>35</b>
<i>OHA’s Accountability in Supporting the Success of CCOs.....</i>	<i>35</i>
<i>CCO Accountability.....</i>	<i>36</i>
<i>Shared Accountability for Long-term Care.....</i>	<i>38</i>
<b>8. Financial Reporting Requirements to Ensure Against Risk of Insolvency.....</b>	<b>39</b>
<i>Audited Statements of Financial Position and Guarantees of Ultimate Financial Risk.....</i>	<i>39</i>

*Financial Solvency* ..... 40

*OHA Monitoring and Oversight* ..... 42

*Public Disclosure of Information* ..... 43

*CCO Licensure* ..... 43

*Corporate Assets and Financial Management* ..... 43

**9. Implementation Plan** ..... **45**

*Transition Strategy* ..... 45

*Transitional Provisions in HB 3650* ..... 45

*Implementation Timeline* ..... 45

**10. Appendices** ..... **47**

DRAFT

## **CCO Implementation Proposal**

### **House Bill 3650 Health Care Transformation**

#### **1. Executive Summary**

Health care costs are increasingly unaffordable—to businesses, individuals, as well as the federal and state government. The growth in Medicaid expenditures far outpaces the growth in general fund revenue, yet there has not been a correlating improvement in health outcomes.

In 2011 the Oregon legislature and Governor John Kitzhaber created Coordinated Care Organizations (CCOs) in House Bill 3650 aimed at achieving the triple aim of improving health, improving health care and lowering costs by transforming the delivery of health care. The legislation builds on the work of the Oregon Health Policy Board since 2009. Essential elements of that transformation are:

- integration and coordination of benefits and services;
- local accountability for health and resource allocation;
- standards for safe and effective care; and
- a global Medicaid budget tied to a sustainable rate of growth.

CCOs are community-based organizations governed by a partnership between providers of care, community members and those taking financial risk. A CCO will have a single global Medicaid budget that grows at a fixed rate, and will be responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid or dually eligible for both Medicaid and Medicare. CCOs will be the single point of accountability for the health quality and outcomes for the Medicaid population they serve. They will also be given the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

CCOs are the next step forward for Oregon's health reform efforts that began in 1989 with the creation of the Oregon Health Plan. Today's managed care organizations, mental health organizations, and dental care organizations that serve our state's Medicaid population have done a good job in keeping health care costs down, but the current structure limits their ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. Additionally, the current payment system provides little incentive for the prevention or disease management actions that can lower costs, and OHP clients face a sometimes dizzying array of plans and rules while health care costs continue to outpace growth in income or state revenues.

Conventional wisdom is that there are three approaches to controlling what is spent on health care: reduce provider payments; reduce the number of people covered; or reduce covered benefits. Over the years these approaches have proven unsuccessful in reducing the actual cost of care and can squelch investments in health improvement that lead to lower future costs.

In the creation of Coordinated Care Organizations, HB 3650 lays the foundation for a fourth pathway: rather than spending less into an inefficient system, change the system for better efficiency, value and health outcomes.

To implement CCOs in our state, lawmakers called on the Oregon Health Authority to develop a proposal for governance, budgeting, and metrics. That proposal has been developed through the Oregon Health Policy Board and is the result of the work of the board and four work groups comprising 133 people who met over four months, a series of eight community meetings around the state that brought input from more than 1,200 people, and public comment at the monthly Oregon Health Policy Board meetings.

*Financial Projections for Greater System Efficiency and Value*

There is ample evidence from initiatives in our local communities that the kind of transformation pointed to by HB 3650 can improve health outcomes and lower costs. National efforts are showing the same results.

Included in the proposal is work conducted on behalf of OHA and the Oregon Health Policy Board by Health Management Associates (HMA) estimates that total Medicaid spending in Oregon can be reduced by over \$1 billion over the next 3 years and \$3.1 billion over the next five years by transforming the way we pay for and deliver health care. They initially assume a phase-in of savings of 10% to 20% in implementation of year one, moving to 40% to 50% in the 2013-2015 biennium. In year one, this equates to \$155 million to \$308 million in total fund (\$58 million to \$115 million general fund) cost reductions, net of new investment. HMA believes these projections are conservative as there are certain opportunities that would move the system beyond what we currently understand as well-managed. It is also possible that greater potential savings could be achieved with faster implementation. Full details of HMA's analysis are included in the proposal.

This proposal outlines operational and key qualification guidelines for CCOs as recommended by the Oregon Health Policy Board, including:

- *Global budget:* CCO global budgets will be developed by OHA to cover the broadest range of funded services for the largest number of beneficiaries possible. OHA will construct the CCO global budgets starting with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets will include services that are currently provided under managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

Once CCOs are phased in, the quality incentives will be incorporated in the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

- *Accountability:* CCOs will be accountable for outcomes that bring better health and more sustainable costs. HB 3650 directed CCOs be held accountable for their performance through public reporting of metrics and contractual quality measures that function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the direction of HB 3650. Accountability measures and performance expectations for CCOs will be introduced in phases to allow CCOs to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards.

An external stakeholder group established a set of principles and recommendations for dimensions of measurement for OHA to use as a guide when establishing outcomes and quality metrics. Upon Legislative approval to go forward, the next step is to establish a committee of technical experts from health plans and health systems to further define these metrics and a reporting schedule. The technical work group will be asked to establish both minimum expectations for accountability as well as targets for outstanding performance.

- *Application process:* Beginning in spring/early summer, prospective CCOs will respond to a non-competitive Request for Applications (RFA) much like the process developed by the federal government for Medicare Advantage plans. The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.
- *Governance:* CCOs will have a governing board with a majority interest consisting of representation by entities that share financial risk as well as representation from the major components of the health care delivery system. CCOs will also convene community advisory councils (CAC) to assure a community perspective and a member of the CAC will serve on the CCO governing board.
- *CCO criteria:* In their applications for certification, CCOs will demonstrate how they intend to and carry out the functions outlined in HB 3650 including:
  - Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;
  - Ensuring member rights and responsibilities;
  - Working to eliminate health disparities among their member populations and communities;

## CCO Implementation Proposal

- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency

Assuming legislative approval, CCO criteria, the Request for Applications (RFA), and a model CCO contract will be publicly posted in spring 2012 so that communities interested in forming CCOs can begin preparing applications.

The Oregon Health Authority and the Oregon Health Policy Board are poised to begin implementation of the transformational change represented in HB3650.

### Timeline

Federal permissions submitted	March 2012
CCO Criteria publicly posted	Spring 2012
Request for Application (RFA) and model contract posted	Spring 2012
Letters of intent submitted to OHA	Spring 2012
Evaluation of initial CCO applications	Spring/early summer 2012
First CCOs certified	June 2012
First CCOs begin enrolling Medicaid members	July 2012

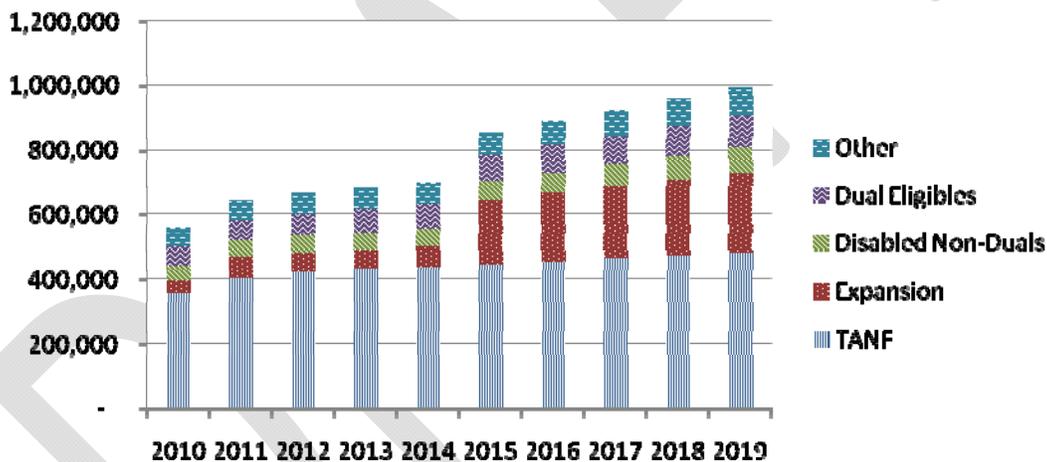
## 2. Existing Market Environment and Industry Analysis

### Target Population

#### Projected Enrollment

The target population includes all current and future Oregon Health Plan (OHP) enrollees. Between 2010 and 2011, enrollment grew rapidly, due primarily to growth within the expansion group. OHP staff estimates project modest (3%) annual enrollment growth through state fiscal year 2014, followed by a rapid jump between 2014 and 2015 when the Affordable Care Act Medicaid expansion goes into effect. While the vast majority of new enrollees are expected to be non-disabled adults, OHP is projecting that the annual rate of growth among the disabled and dual-eligibles, which is approximately 6 percent (excluding the year of the Medicaid expansion), will be roughly three times that of the TANF-related population’s 2%. This trend is critical, as the disabled and dual-eligible populations are, on average, far more costly than their TANF-related counterparts, and also stand to benefit most from effective care management.

**Figure 1: Projected Enrollment by Sub-group**



The following table shows the demographic distribution of the Oregon Medicaid population in 2011. The racial/ethnic makeup of the population has remained virtually unchanged over the last three years. The age profile of the Oregon Medicaid population has also remained stable over the last three years, though there has been a slight shift from the 0-18 age group to the adult group. This trend is expected to be much larger beginning in 2014, as the majority of new Medicaid enrollees will be previously uninsured adults. Approximately 56 percent of Medicaid enrollees are women and 44 percent are men. While this distribution has remained constant over the last several years, it is expected to shift somewhat toward men when the 2014 expansion is implemented.

**Table 1: Oregon Medicaid Demographics (2011)**

Demographic	% (2011)
<b>Race/Ethnicity</b>	
White	61%
African American	4%
Hispanic or Latino	22%
Asian, Native Hawaiian or Other Pacific Islander	3%
American Indian or Alaska Native	2%
Other/Unknown	8%
<b>Age</b>	
0-18	56%
19-64	37%
65+	7%
<b>Gender</b>	
Male	44%
Female	56%

Table 1: Data were extracted from the demographic reports published by the Oregon Health Plan, July 2011.

### ***Current Delivery System for Target Population***

The current OHP program is fragmented, resulting in diluted accountability for patient care and likely duplication of infrastructure and services. Care is delivered through a system that includes three kinds of health plans (16 physical health organizations, 10 mental health organizations and eight dental care organizations), while some individuals continue to receive care on a fee-for-service basis. Specifically:<sup>1</sup>

- Approximately 78% of OHP clients are enrolled in physical health managed care.
- Nearly 90% of OHP clients are enrolled in managed dental care.
- Approximately 148,000 clients not enrolled in managed care receive services on a Fee-for-Service (FFS) arrangement – providers bill the state directly for their services based on a set fee schedule. Some providers receiving FFS also get a case management fee (in areas where there are no managed care plans).
- 88% of OHP enrollees are enrolled in capitated mental health organizations (MHOs). In many cases, the state provides capitated mental health organization (MHO) payments to the counties and the counties administer the programs. The counties function as the MHO, bearing full risk for the services, and contract with panels of providers to provide direct services to enrollees. Addiction services for Medicaid clients are covered in fully capitated health plans, not through MHOs or counties.

Please see Appendix A for detailed information on current plan types and service areas.

<sup>1</sup> Oregon Health Authority. Oregon Health Policy Board Meeting slides, January 18, 2011

### ***Population Characteristics and Health Status***

The need for more effective service integration and care management for OHP enrollees is evident in statewide and Medicaid-specific data. This section provides an overview of several key indicators of population health. Many of these indicators are also reflective of major cost-drivers within the Medicaid program.

- *Perinatal Indicators.* Maternal and child health indicators are important factors in assessing the relative health of a community. Risk factors for poor birth outcomes such as low birth weight, short gestation, maternal smoking, inadequate maternal weight gain during pregnancy and substance abuse can often be addressed as a woman receives prenatal care.
- *Chronic Conditions.* Experts estimate that chronic diseases are responsible for 83 percent of all health care spending.<sup>2</sup> Health care spending for a person with one chronic condition on average is two and a half times greater than spending for someone without any chronic conditions.<sup>3</sup>
- *Smoking.* Direct Oregon Medicaid costs related to smoking are an estimated \$287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon.<sup>4</sup> While overall tobacco use rates in Oregon are below national levels and trending downward, adult Medicaid clients are nearly twice as likely to smoke as Oregon adults in general.<sup>5</sup> Specifically, 37 percent of adult Medicaid clients smoke, compared to 17 percent of Oregon adults. In addition, studies have shown that economic status is the single greatest predictor of tobacco use.<sup>6</sup>
- *Obesity.* Similarly, Medicaid payments for obesity-related care accounted for nearly nine percent of Medicaid costs between 2004 and 2006, a figure that has likely grown as obesity rates have increased.<sup>7</sup>

The following chart show statewide trends in perinatal indicator rates for the Medicaid population. Teen birth rates and low birth rate babies have remained relatively constant over the past ten years. However, rates of late prenatal care have shown a troubling increase, and the percentage of Medicaid enrollees who smoke during their pregnancy has increased after dropping off in 2007.

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<sup>2</sup> Partnership for Solutions, *Chronic Conditions: Making the Case for Ongoing Care*. September 2004 Update.

<sup>3</sup> Ibid

<sup>4</sup> OREGON HEALTH PLAN, *Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations*, May 2011.

<sup>5</sup> Ibid.

<sup>6</sup> Ibid.

<sup>7</sup> Portland Pulse, from 2007 Oregon DHS data, see: <http://www.portlandpulse.org/node/37>

**Figure 2: Perinatal Indicators for the OHP Population**

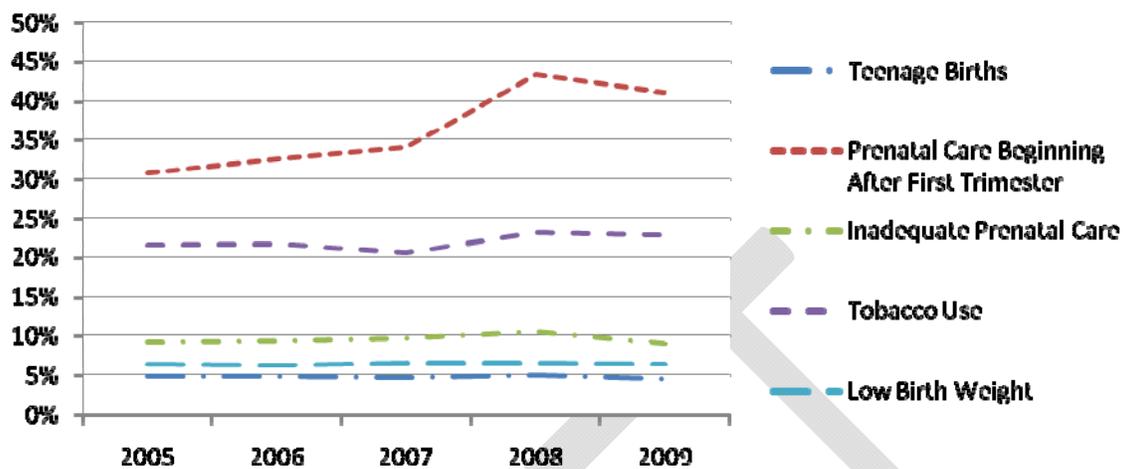


Figure 2: Oregon Vital Statistics Annual Reports 2005-2009

Figure 3 below shows the variation across the state when looking at the prevalence of chronic conditions among current OHP enrollees based on diagnosis codes. The statewide bar shows the average across all seven regions for each of the seven chronic conditions. The regions are defined as follows:

- Region 1: Clatsop, Columbia, Tillamook, Lincoln
- Region 2: Coos, Curry
- Region 3: Benton, Clackamas, Linn, Marion, Multnomah, Polk, Washington, Yamhill
- Region 4: Douglas, Jackson, Josephine, Lane
- Region 5: Crook, Deschutes, Gilliam, Grant, Hood River, Jefferson, Morrow, Sherman, Wasco, Wheeler
- Region 6: Baker, Umatilla, Union, Wallowa
- Region 7: Klamath, Lake, Henry, Malheur

In many instances, there are large disparities across regions. For example, Region 2’s population has a diabetes prevalence rate that exceeds the statewide average by more than 30 percent and exceeds the Region 5 prevalence rate by 42 percent. Similarly, Region 2’s population has an asthma prevalence rate that exceeds the statewide average by 14 percent and the Region 6 rate by 25 percent.

**Figure 3: Rates of Chronic Conditions Per 1,000 Clients**

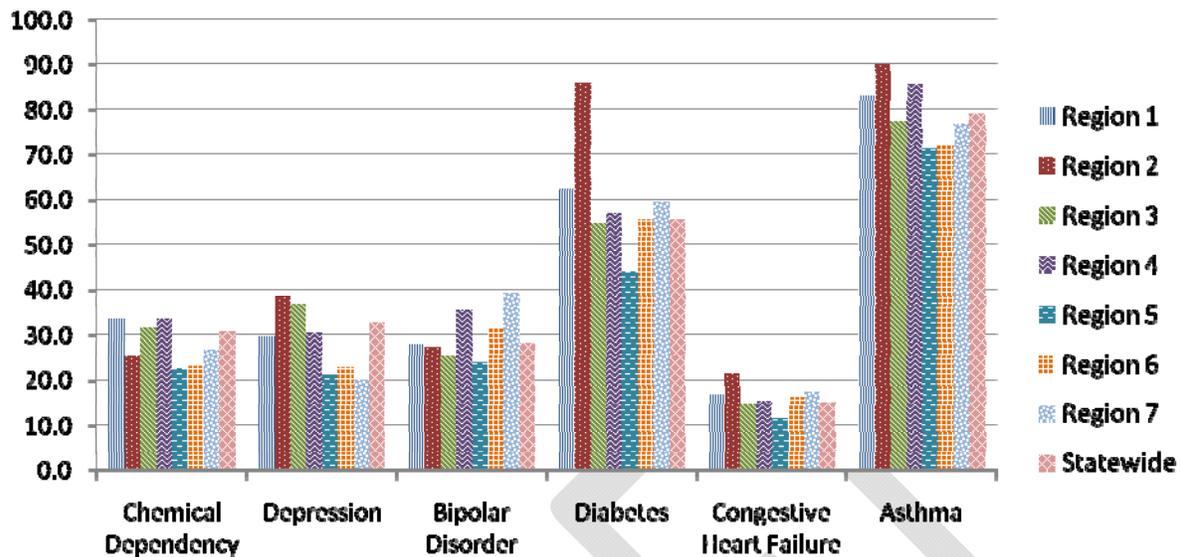


Figure 3: Oregon Health Authority Division of Medical Assistance Programs 8/15/2011.

Figure 4 below illustrates the overweight/obesity trend in Oregon and nationally. The lower portion of each stack represents the percent of the population considered “obese” according to their body mass index (BMI). The total stack represents the percentage of the population considered “overweight or obese”. While the percentage of the Oregon population considered “overweight or obese” has stayed relatively stable from 2002-2009, the portion that are classified as “obese” has grown. While overall rates of obesity in Oregon are below national levels, this is a troubling trend, as obesity is one of the most important risk factors for developing diabetes, as well as numerous other chronic conditions and certain types of cancer.

**Figure 4: Percent of Population Overweight and Obese**

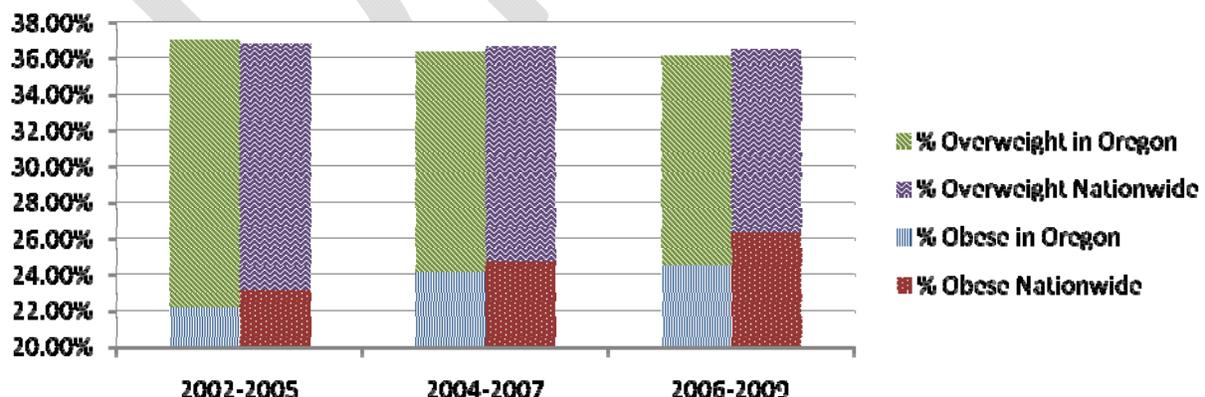


Figure 4: The lower stacks represent the percentage of the population classified as "obese". The total stacks represent the percentage of the population considered "overweight". The data comes from the Behavioral Risk Factor Surveillance System, accessed 12/2011.

Racial and Ethnic Disparities

In addition to overall rates of chronic disease and utilization of preventive services, it is important to look at disparities among racial and ethnic groups. A 2008 study by the Oregon Division of Medical Assistance compared racial and ethnic disparities in Oregon and in the Oregon Health Plan and found that disparities exist but vary by race/ethnic group.<sup>8</sup> The prevalence of chronic disease is worse among certain minority groups compared to whites. For Oregon Health Plan clients, asthma prevalence was higher for American Indians and Alaska Natives than for any other group – and other minority groups’ prevalence was lower than whites’. For Oregon Health Plan clients, all minority groups had a higher prevalence of diabetes, except for African Americans, where the prevalence was the same as for whites.

In its 2011 “State of Equity Report,” the Department of Human Services and the Oregon Health Authority identified two disparities in key performance measures across race and ethnicity. For the first measure, the utilization rate of preventative services for children from birth to 10 years of age covered by the Oregon Health Plan, a higher rate is favorable. When comparing across the benchmark of non-Hispanic whites, the chart shows Native Americans utilizing preventative services at a rate of less than 75% of the utilization seen in the white population.

**Figure 5: Utilization Rate of Preventive Services for Children 0-10 Years Old Covered by the OHP Per Person Year - 2009**

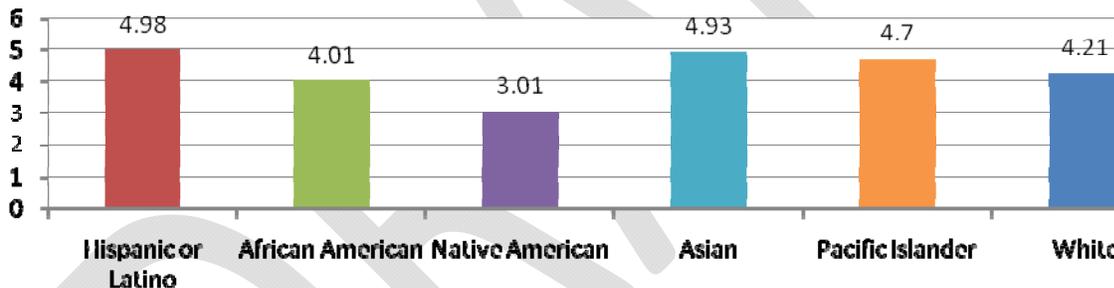


Figure 5: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011. Rates reflect the number of preventive services provided per person year.

In the second measure, the rate of ambulatory care sensitive condition hospitalizations of OHP clients, a lower rate is more favorable. Again, when comparing rates to the benchmark of non-Hispanic whites, the Native American population showcases less positive measures. High rates of hospitalization for ambulatory care sensitive conditions indicate that a condition is not being properly managed. These two disparities together highlight a population in which there is a lack of health care needs being met and indicate a need for outreach and interventions targeted to specific groups.

<sup>8</sup> Division of Medical Assistance Programs and the Public Health Division, “Oregon Department of Human Services’ Efforts to Reduce Racial and Ethnic Health Care Disparities.” May 23, 2008.

**Figure 6: Rate of Ambulatory Care Sensitive Condition Hospitalizations of OHP Clients per 100,000 Person Years - 2009**

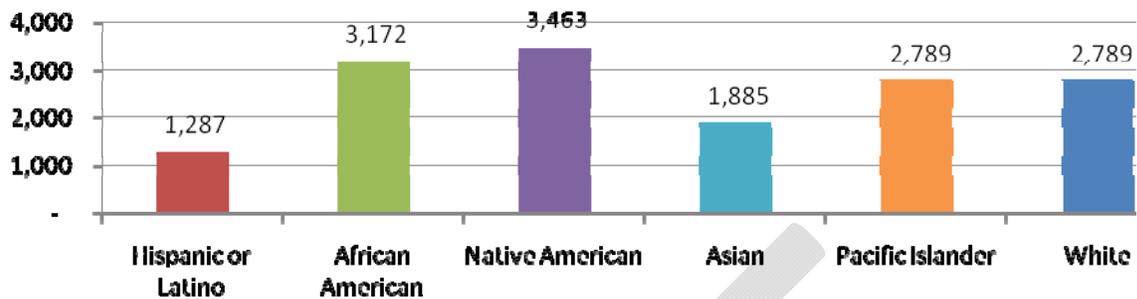
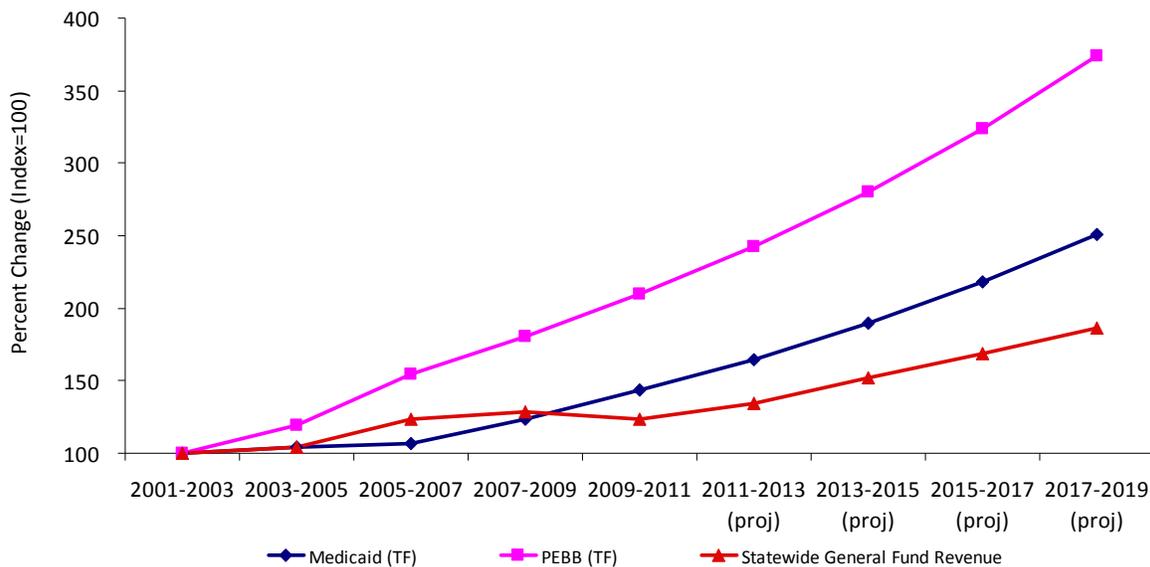


Figure 6: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011.

Unsustainable Cost Growth

While the rate of cost growth in the Medicaid program was effectively controlled in the early 2000s, the rate of growth has increased significantly and now far exceeds the current and projected rate of increase in state General Fund revenue (see Figure below). This trend is clearly unsustainable.

**Comparing the rate of increase in Medicaid and PEBB health care expenditures vs rate of increase in state General Fund revenue**



### **3. Opportunities for Achieving the Triple Aim: Improving Health, Improving Health Care and Reducing Cost**

#### ***Financial Projections for Greater System Efficiency and Value***

##### Current State

For the year ending June 30, 2013, total Oregon Medicaid payments are expected to approach \$3.2 billion. Oregon's Medicaid enrollment has been growing in recent years and the base cost for services has increased historically and is expected to continue to do so. Inflationary factors include higher wages for care providers, changes in medical practice, and the introduction of new treatment protocols and new drugs and technology.

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as \$11.7 billion in the FY 2017/2019 biennium with over 950,000 individuals enrolled in the program. This figure includes about 250,000 newly-eligible under federal health reform expansion provisions that take effect in 2014.

HB 3650 directs OHA to "prepare financial models and analyses to demonstrate the feasibility of a coordinated care organization being able to realize health care cost savings." OHA contracted with Health Management Associates to conduct this analysis.

##### Estimates of Health Transformation Savings provided by Health Management Associates

The HMA analysis projects potential savings in six areas:

- Improved management of the population
- Integration of Physical and Mental Health
- Implementation of the Mental Health Preferred Drug List
- Increased Payment Recovery Efforts
- Patient Centered Primary Care Homes
- Administrative Savings from MCO Reductions

##### Improve to a well-managed system of care

In 2011, a report by Milliman for the Portland area Oregon Health Leadership Council projected savings for a well-managed Medicaid sub-population (TANF) between \$118 million and \$141 million statewide. According to Milliman, well-managed status reflects attainment of utilization at defined levels equal to optimal benchmarks. Savings reflect the difference between existing service levels and those benchmarks. HMA projected those findings to the entire Medicaid population by extending Milliman projections to the additional Medicaid populations: aged, blind and disabled and the expansion

population. HMA considers these projections conservative because the complexity and level of chronic disease in these groups is higher and generally yields higher savings.

HMA states that the overall integration of care and payment mechanisms would reduce costs primarily on the Medicare side for dually eligible individuals. Based upon a study by the Lewin Group and in conjunction with the report from Milliman, they have estimated this rate at 8.5%. These savings come primarily from Medicare expenditures and a shared savings arrangement with Medicare is essential to obtaining a benefit to the State.

#### Integration of Physical and Mental Health

A key strategy in Oregon's health system transformation efforts includes the integration of mental health and physical health. A study of integration savings projected results as high as 20% to 40%; however, HMA assumed a lower figure of 10 to 20% given the extent of other savings already applied in Oregon. This includes both the integration of physical health with certain mental health settings as well as the addition of mental health with physical health settings. Further, while HMA did not estimate the benefit of integrating dental health into the overall system, increased coordination should also reduce costs and increase the quality of the consumer's experience.

#### Implementation of Mental Health Preferred Drug List

This strategy will require legislative approval, so no savings are projected for year one. Clear evidence exists to demonstrate savings while maintaining the same level of treatment outcomes.

#### Increased Payment Recovery Efforts

CCOs will audit claims to review Medicaid coverage criteria, inappropriate coding assignments, medical necessity, third party liability, coordination of benefits and other targeted areas, and recoup overpayments.

#### Patient Centered Primary Care Medical Homes

The statewide implementation of the patient-centered primary care home model can further reduce costs. Early implementation of similar models has been shown to reduce total expenditures by up to 7%. By further enhancing the abilities of these homes through connections to specialty care and improving care transitions between levels of care, we believe you can go beyond well managed.

#### Administrative Savings from MCO Reductions

CCOs will be larger and more comprehensive than existing MCOs and MHOs. Consequently, economies of scale are available from the consolidation and redesign of current administrative functions.

#### Electronic Health Records and Health Information Exchange

While not included in the table below, the savings from electronic connectivity and reduction in duplicate testing should be noted. Witter & Associates, LLC, estimate avoided services savings at \$16 million a year from the widespread adoption and use of health information exchange (HIE). While implementation of statewide HIE is projected to take four to five years, the resultant savings over time

are substantial. These estimates are not net of provider and health system implementation costs. However, the federal investment in provider incentive payments is providing considerable financial support for these efforts. Additionally, we believe that the savings would be measurable if the costs of implementation could be shared across other payers.

**HMA Estimates of Achievable Medicaid Savings Due to Health System Transformation**  
(each column represents expenditures and savings for that period only)

<b>LOW SAVINGS – Total Funds</b>	<b>7/12 to 6/13</b>	<b>7/13 to 6/15</b>	<b>7/15 to 6/17</b>	<b>7/17 to 6/19</b>
Average Enrolled	672,430	733,522	887,750	955,475
<b>Projected Expenditures</b>	<b>\$3,178,000,000</b>	<b>\$7,439,550,000</b>	<b>\$10,018,650,000</b>	<b>\$11,680,350,000</b>
Improve to "Well Managed"	(\$43,700,000)	(\$311,050,000)	(\$972,900,000)	(\$1,282,700,000)
Integration of Physical and Mental Health	(\$31,300,000)	(\$285,100,000)	(\$678,400,000)	(\$1,039,800,000)
Mental Health Preferred Drug List	\$0	(\$16,000,000)	(\$27,000,000)	(\$53,100,000)
RAC and Other Audits	(\$62,700,000)	(\$142,600,000)	(\$180,900,000)	(\$208,000,000)
Patient Centered Primary Care Homes	(\$11,000,000)	(\$99,800,000)	(\$237,500,000)	(\$363,900,000)
Admin Savings from MCO Reductions	(\$6,300,000)	(\$14,300,000)	(\$18,100,000)	(\$20,800,000)
<b>Savings from Redesign</b>	<b>(\$155,000,000)</b>	<b>(\$868,850,000)</b>	<b>(\$2,114,800,000)</b>	<b>(\$2,968,300,000)</b>
	<b>\$3,023,000,000</b>	<b>\$6,570,700,000</b>	<b>\$7,903,850,000</b>	<b>\$8,712,050,000</b>
	-4.9%	-11.7%	-21.1%	-25.4%
<b>HIGH SAVINGS – Total Funds</b>	<b>7/12 to 6/13</b>	<b>7/13 to 6/15</b>	<b>7/15 to 6/17</b>	<b>7/17 to 6/19</b>
Average Enrolled	672,430	733,522	887,750	955,475
<b>Projected Expenditures</b>	<b>\$3,178,000,000</b>	<b>\$7,439,550,000</b>	<b>\$10,018,650,000</b>	<b>\$11,680,350,000</b>
Improve to "Well Managed"	(\$65,500,000)	(\$401,050,000)	(\$1,113,400,000)	(\$1,603,850,000)
Integration of Physical and Mental Health	(\$124,500,000)	(\$703,900,000)	(\$1,781,100,000)	(\$2,015,300,000)
Mental Health Preferred Drug List	\$0	(\$16,000,000)	(\$27,000,000)	(\$51,800,000)
RAC and Other Audits	(\$62,300,000)	(\$140,800,000)	(\$178,100,000)	(\$201,500,000)
Patient Centered Primary Care Homes	(\$43,600,000)	(\$246,300,000)	(\$623,400,000)	(\$705,400,000)
Admin Savings from MCO Reductions	(\$12,500,000)	(\$28,200,000)	(\$35,600,000)	(\$40,300,000)
<b>Savings from Redesign</b>	<b>(\$308,400,000)</b>	<b>(\$1,536,250,000)</b>	<b>(\$3,758,600,000)</b>	<b>(\$4,618,150,000)</b>
	<b>\$2,869,600,000</b>	<b>\$5,903,300,000</b>	<b>\$6,260,050,000</b>	<b>\$7,062,200,000</b>
	-9.7%	-20.6%	-37.5%	-39.5%

#### **4. Coordinated Care Organization (CCO) Certification Process**

Pending direction and approval by the Legislature during the February 2012 session, the Oregon Health Authority will begin a non-competitive Request for Applications (RFA) procurement process that specifies the criteria organizations must meet to be certified as a CCO. Prospective CCOs will be asked to submit applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650, including being prepared to enroll all eligible persons within the CCO's proposed service area.

In early spring 2012, OHA will promulgate administrative rules describing the CCO application process and criteria. Once the criteria have been finalized, the application process for prospective CCOs is planned as follows: (see Section 9 of this document for a timeline):

- CCO criteria will be posted online by OHA
- OHA will release a "Request for CCO Application"
- CCO applicants will submit letters of intent to OHA
- CCO applicants will submit applications to OHA
- OHA will evaluate CCO applications
- OHA will certify CCOs
- CMS will collaborate with OHA evaluation of applications and certification of CCOs, or may follow with a separate certification with respect to individuals who are dually eligible

Because CCOs will be responsible for integrating and coordinating care for individuals who are dually eligible for Medicare and Medicaid, the application will include the relevant Medicare plan requirements that will build on the existing CMS Medicare Advantage application process, streamlining the process for any plans that have previously submitted Medicare Advantage applications. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

Evaluation of CCO applications will account for the developmental nature of the CCO system. CCOs, OHA and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by HB 3650. In all cases, CCOs will be expected to have plans in place for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by HB 3650.

#### ***Alternative Dispute Resolution***

- ***Section 8(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.***
- ***Section 8 (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.***
- ***Section 8 (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for***

***services that are available through a coordinated care organization either directly or by contract.***

- ***Section 8 (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.***

Regarding the creation of CCOs, requires the development of a dispute resolution process. If a health care entity (HCE) is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization, a process will be available to those parties that includes the use of an independent third party arbitrator. A more complete description of the proposed process is provided in Appendix C. A summary of the primary objectives and components of the process is provided here.

A dispute resolution process using an arbitrator will follow after a good faith effort between the parties to agree to mutually satisfactory contract terms. If there is a question about whether the HCE is “necessary” for the certification of the CCO, the parties can consult with OHA. If there are technical questions that OHA can assist the parties with concerning the certification process, this consultation will be available. However, the primary goal is for the parties who are necessary to the certification of a CCO to work together to agree upon the terms of a contract. Evidence of good faith negotiations should include at least one face-to-face meeting between the Chief Executive Officer and/or Chief Financial Officer of the HCE and of the organization applying for CCO certification, to discuss the contract offer that has been made and the reasons why the HCE has not accepted the offer. If that process does not result in a contract, either party can request the use of an arbitrator.

This dispute resolution process using an arbitrator applies when (and only when) an HCE is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization. This process is designed to be completed within 60 calendar days. When one party initiates the dispute resolution process, the other party and OHA will receive written notification. The parties will then identify a mutually acceptable arbitrator, who must be familiar with health care issues and HB 3650, and who agrees to follow the dispute resolution process described in Appendix C. In the first 10 days, both parties must send their most reasonable contract offer to each other and the arbitrator, or an explanation of why no contract is desired; in the next 10 days, the parties can file a written explanation for why the offer or refusal to contract is reasonable or unreasonable. The arbitrator has 15 days to review these materials and issue a decision about whether the HCE refusal to contract is reasonable or unreasonable. Having received the decision, the parties have an additional 10 days to resolve their dispute and agree on a contract. At any point in the process, the parties can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

## 5. Coordinated Care Organization (CCO) Criteria

In order to be certified as a CCO, organizations will be asked to address the criteria outlined in Sections 4 through 13 of HB 3650 and to illustrate how their organization and systems support the Triple Aim. OHPB recommendations for CCO criteria, outlined below, were developed from a combination of stakeholder workgroup input, public comment, OHPB-sponsored community meetings held throughout the state, and public and invited testimony at Board meetings, as well as Board deliberations. Appendix D contains a consolidated list of the proposed CCO criteria along with minimum and transformational expectations for each criterion.

### ***Governance and organizational relationships***

- ***Section 4(1)(o)(A-C): (o) Each CCO has a governance structure that includes: (A) a majority interest consisting of persons that share the financial risk of the organization; (B) the major components of the health care delivery system, and (C) the community at large to ensure that the organization's decision-making is consistent with the values of the members of the community.***
- ***Section 4(1)(i) 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 membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met.***
- ***Section 4(2) The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.***
- ***Section 4(3) On or before July 1, 2014, each CCO will have a formal contractual relationship with any DCO in its service area.***
- ***Section 24(1-4): CCOs shall have agreements in place with publicly funded providers to allow payment for point of contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.***

### Governing Board

CCO organizational structures will vary to meet the needs of the communities they will serve. There is no single governance solution, and there is risk in being too prescriptive beyond the statutory definition of a CCO governing board. Instead, governing board criteria will support a sustainable, successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim.

As part of the certification process, a CCO should articulate:

- How individuals bearing financial risk for the organization make up the governing board's majority interest,
- How the governing board includes members representing major components of the health care delivery system,
- How consumers will be represented in the portion of the governing board that is not composed of those with financial risk in the organization; and
- How the governing board makeup reflects the community needs and supports the goals of health care transformation.
- What are the criteria and process for selecting members on the governing board, CAC and any other councils or committees of the governing board?

#### Community Advisory Council (CAC)

HB 3650 requires that each CCO convene a Community Advisory Council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership. It further requires that the CAC meets regularly to ensure that the health care needs of the consumers and the community are being met.

At least one member from the Community Advisory Council (chair or co-chairs) will also serve on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations. There must be transparency and accountability for the governing board's consideration and decision making regarding recommendations from the CAC.

#### Clinical Advisory Panel

Potential CCOs will establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices. Representation on the governing board should be required, as with the Community Advisory Council.

In addition, the CCO will need to address the following in its application:

- How will the CAC and any other councils or committees of the governing board support and augment the effectiveness of governing board decision-making?
- What are the structures initially and over time that will support meaningful engagement and participation of CAC members, and how will they address barriers to participation?

#### Partnerships

HB 3650 encourages partnerships between CCOs and local mental health authorities and county governments in order to take advantage of and support the critical safety net services available through county health departments and other publicly supported programs. Unless it can be shown why such arrangements would not be feasible, HB 3650 requires CCOs to have agreements with the local mental health authority regarding maintenance of the mental health safety net and community mental health needs of CCOs members, and with county health departments and other publicly funded providers for

payment for certain point-of-contact services. OHPB directs OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.

### Community Needs Assessment

CCOs should partner with their local public health authority and hospital system to develop a shared community needs assessment that includes a focus on health disparities in the community. The needs assessment will be transparent and public in both process and result. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, OHA should work with communities and other relevant bodies such as the OHA Office of Equity and Inclusion and the Health Information Technology Oversight Council (HITOC) to create as much standardization as possible in the components of the assessment and data collection so that CCO service areas can be meaningfully compared, recognizing that there will be some differences due to unique geographic settings and community circumstances.

In developing a needs assessment, CCOs should meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community need that builds on community resources and skills and emphasizes innovation. OHA will define the minimum parameters of the community needs assessment with the expectation that CCOs will expand those as necessary to identify the needs of the diverse communities in the CCO service area. The Public Health Institute's "Advancing the State of the Art in Community Benefit" offers a set of principles that provide guidance for this work<sup>9</sup>:

- Emphasis on disproportionate unmet, health-related need
- Emphasis on primary prevention
- Building a seamless continuum of care
- Building community capacity
- Emphasis on collaborative governance of community benefit

### ***Patient Rights and Responsibilities, Engagement, and Choice***

- ***Section 4(1)(a) Each member of the CCO receives integrated person-centered care and services designed to provide choice, independence and dignity.***
- ***Section 4(1)(h) Each CCO complies with safeguard for members as described in Section 8, Consumer and Provider Protections of HB 3650:***
  - ***Section 8(1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:***
    - (a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.***

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<sup>9</sup> Public Health Institute, *Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability*, November, 2004.

- (b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.***
- (c) Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.***
- (d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.***
- (e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.***
- ***Section 4(1)(k) Members have a choice of providers within the CCOs network and that providers participating in the CCO: (A) work together to develop best practices for care and delivery to reduce waste and improve health and well-being of members, (B) are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history, (C) emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication, (D) are permitted to participate in networks of multiple CCOs, (E) include providers of specialty care, (F) are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards, (G) 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.***

Members enrolled in CCOs should be actively engaged partners in the design and, where applicable, implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices should be reflected in the development of treatment plans and member dignity will be respected. Under this definition, members will be better positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against underutilization of services and inappropriate denials of services.

In addition to any other consumer rights and responsibilities established by law, CCOs should demonstrate how they will:

- Determine the best patient engagement approaches and barriers by engaging the community and via the community needs assessment.
- Encourage members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members.
- Engage members in culturally appropriate ways.
- Educate members on how to navigate the coordinated care approach.

- Encourage members to use wellness and prevention resources and to make healthy lifestyle choices.
- Meaningfully engage the Community Advisory Council to monitor patient engagement and activation.

***Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements***

- ***Section 4(1)(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.***
- ***Section 4(1)(c) 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.***
- ***Section 4(1)(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.***
- ***Section 4(1)(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health interpreters, community health workers, and personal health navigators who meet competency standards developed by the Authority.***
- ***Section 4(1)(f) 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.***
- ***Section 4(1)(j) 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.***
- ***Sec 4(1)(k)(G) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Section 4(1)(n) Each CCO participates in the learning collaborative described in ORS 442.210(3).Section 6(2) 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.***
- ***Section 6(3) Standards established by the authority for the utilization of patient centered primary care homes by CCOs may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.***

- ***Sec 20(4) 'Community health worker' means an individual who:***
  - c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;***
  - d) Assists members of the community to improve their health and increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness;***
  - e) Provides health education and information that is culturally appropriate to the individuals being served;***

Transformation relies on ensuring that CCO members have access to high quality care. This will be accomplished by the CCO through a provider network capable of meeting health systems transformation objectives. The following criteria focus on elements of a transformed delivery system critical to improving the member's experience of care as a partner in care rather than as a passive recipient of care.

#### Patient-Centered Primary Care Homes

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon's statewide standards. These standards were developed through a public process as directed by HB 2009 to advance the Triple Aim goals of better health, better care, lower costs by focusing on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's (and family's) physical and behavioral health care needs.

Building on this work, CCOs will demonstrate how they will use PCPCH capacity to achieve the goals of health system transformation including:

- How the CCO will partner with and/or implement a network of patient-centered primary care homes as defined by Oregon's standards to the maximum extent feasible, as required by HB 3650.
- How the CCOs will require their other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, as required by HB 3650.
- How the CCO will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650, and members' experience of care and outcomes are improved. Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation.
- How the CCO's patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and services, as described in the bill, and that members are fully informed partners in transitioning to this model of care.
- How members will be informed about access to non-traditional providers, if available through the CCO. As described in HB 3650, these providers may include personal health navigators, peer

wellness specialists where appropriate, and community health workers who, as part of the care team, provide culturally and linguistically appropriate assistance to members to access needed services and participate fully in all in processes of care.

### Care Coordination

Care coordination is a key activity of health system transformation. Without it, the health system suffers costly duplication of services, conflicting care recommendations, medication errors, and member dissatisfaction, which contribute to poorer health outcomes and unnecessary increases in medical costs.

CCOs should demonstrate the following elements of care coordination in their applications for certification:

- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and a standardized follow-up approach in the absence of full health information technology capabilities.
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services.
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication.

CCO applicants should be able to describe the evidence-based or innovative strategies they will use within their delivery system networks to ensure coordinated care, especially for members with intensive care coordination needs, as follows.

- *Assignment of responsibility and accountability:* CCOs must demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions, as required by HB 3650.
- *Individual care plans:* As required by HB 3650, CCOs will use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.
- *Communication:* CCOs will demonstrate that providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record (her) capabilities, etc.).

Effective transformation requires the development of a coordinated and integrated delivery system provider network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. OHPB understands this work will occur over time. As each CCO develops, it will be expected to demonstrate:

- How it will ensure a network of providers to serve members' health care and service needs, meet access-to-care standards, and allow for appropriate choice for members as required by HB

3650. The bill also requires that services and supports should be geographically as close to where members reside as possible and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

- How it will build on existing provider networks and transform them into a cohesive network of providers.
- How it will work to develop formal relationships with providers, community health partners, and state and local government support services in its service area(s), as required by HB 3650, and how it will participate in the development of coordination agreements between those groups.

#### Care Integration

- *Mental Health and Chemical Dependency Treatment:* Outpatient mental health and chemical dependency treatment will be integrated in the person-centered care model and delivered through and coordinated with physical health care services by the CCO. HB 3650 requires OHA to continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a CCO but no later than July 1, 2013.
- *Oral Health:* By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside. Shared financial accountability will encourage aligned financial incentives for cost-effectiveness and to discourage cost shifting.
- *Hospital and Specialty Services:* Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes and that specify: processes for requesting hospital admission or specialty services; performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care.

#### Quality Assurance and Improvement

It is a continued goal of the OHA to require contracted Medicaid providers to meet established standards for quality assessment and improvement. As part of the certification process, CCOs will describe planned or established mechanisms for:

- A complaint/grievance and appeals resolution process, including how that process will be for communicated to members and providers;
- Establishing and supporting an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops;
- Participating in data collection and/or reporting for OHA accountability metrics;
- Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.

### **Health Equity and Eliminating Health Disparities**

- **Section 2(2).** *The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.*
- **Section 2(3)(b).** *The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including progress toward eliminating health disparities.*
- **Sec 4(1)(f)** *Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.*
- **Section 4(1)(k)(G).** *[Providers participating in a Coordinated Care Organization] work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.*
- **Sec 19(1)(L)** *The authority shall: Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).*
- **Sec 30(1)(a)** *Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:*
  - (a) Demographics, including race and ethnicity.*
  - (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.*

Health equity means reaching the highest possible level of health for all people. Historically, health inequities result from health, economic, and social policies that have disadvantaged communities. These disadvantages result in tragic health consequences for vulnerable populations and increased health care costs to the entire system, costs which are borne by taxpayers, employers, workers, and the uninsured. CCOs will ensure that everyone is valued and health improvement strategies are tailored to meet the individual needs of all members, with the ultimate goal of eliminating health disparities.

HB 3650 encourages CCOs and their associated providers to work together to develop best practices of culturally appropriate care and services delivery to reduce health disparities and improve health and well-being of members. Through their community needs assessment, CCOs will be expected to identify

health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, or other factors in their service areas. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, the OHA Office of Equity and Inclusion should assist in identifying standard components (e.g., workforce) that CCOs should address in the assessment to ensure that all CCOs have a strong and comparable set of baseline data on health disparities.

CCOs will be expected to collect or maintain race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards jointly established by OHA and Oregon's Department of Human Services. CCOs can then track and report on any quality measure by these demographic factors and will be expected to develop, implement, and evaluate strategies to improve health equity among members.

### ***Payment Methodologies that Support the Triple Aim***

- ***Section 5(1). The OHA shall encourage CCOs to use alternative payment methodologies that: (a) reimburse providers on the basis of health outcomes and quality instead of the volume of care; (b) hold organizations and providers responsible for the efficient delivery of quality care; (c) reward good performance; (d) limit increases in medical costs; (e) use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination.***

To encourage improved quality and efficiency in the delivery of services, it will be necessary for CCOs to move from a predominantly fee-for-service system to alternative payment methods that base reimbursement on the quality rather than quantity of services provided. CCOs will be expected to demonstrate how their payment methodologies promote the following principles:

- Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;
- Hold organizations and providers accountable for the efficient delivery of quality care;
- Limit increases in medical costs;
- Promote prevention, early identification and intervention of conditions that lead to chronic illnesses;
- Provide comprehensive coordination or create shared responsibility across provider types and levels of care, using such delivery systems such as patient-centered primary care homes; and
- Utilize evidence-based practices and health information technology to improve health and health care.

While CCOs will have flexibility in the payment methodologies they choose to use, CCOs are encouraged to rely on previously developed and tested payment approaches where available. Efforts to create incentives for evidence-based and best practices will be expected to increase health care quality and patient safety and to result in more efficient use of health care services. To ensure successful transition to new payment methods, it will be necessary for CCOs to build network capacity and to help restructure systems and workflows to be able to respond effectively to new payment incentives.

### **Health Information Technology**

- **Section 4(1)(g) Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent possible.**

OHPB requested that the Health Information Technology Oversight Council (HITOC) provide advice on appropriate health information technology (HIT) certification criteria for CCOs. In order to ensure that coordinated care delivery is enabled through the availability of electronic information to all participants, HITOC suggests that CCOs will need to develop the HIT capabilities described below. CCOs will span different provider types across the continuum of care and different geographic regions across the state, each of which is at different stages of HIT adoption and maturity. The proposed approach for achieving advanced HIT capability is to meet providers and communities where they are and require improvement over time. CCOs will ultimately need to achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and to develop their own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement, and other health IT).

#### Electronic Health Records Systems (EHRs)

CCOs should facilitate providers' adoption and meaningful use of EHRs. EHRs are a foundational component of care coordination because they enable providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to achieve advanced EHR adoption and meaningful use, CCOs will be expected to:

- Identify EHR adoption rates; rates may be divided by provider type and/or geographic region.
- Develop and implement strategies to increase adoption rates of certified EHRs.
- Consider establishing minimum requirements for EHR adoption over time. Requirements may vary by region or provider type;

#### Health Information Exchange (HIE)

CCOs will facilitate electronic health information exchange in a way that allows all providers to exchange a patient's health information with any other provider in that CCO. HIE is a foundational component of care coordination because it enables providers to access pertinent health information when and where it is needed to provide the best care possible and to avoid performing duplicative services. CCOs will be expected to ensure that every provider is:

- **Either** registered with a statewide or local Direct-enabled Health Information Service Provider (HISP)
  - Direct is a way for one provider to send secure information directly to another provider without using sophisticated information systems. Direct secure messaging will be available to all providers as a statewide service, and while EHR vendors will continue to develop products with increasingly advanced Direct functionality, using Direct secure messaging does not require an EHR system. Registration will ensure the proper identification of

participants and secure routing of health care messages, and the e-mail address provided with Direct secure messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time.

- **Or** is a member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

CCOs should also consider establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

CCOs will leverage HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, CCOs should initially identify their current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in the following areas:

- Analytics (to assess provider performance, effectiveness and cost-efficiency of treatment, etc.)
- Quality Reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the performance of the CCO)
- Patient Engagement through HIT (using existing tools such as e-mail, etc.)
- Other HIT (telehealth, mobile devices, etc.)

## 6. Global Budget Methodology

- Section 13(2)(b) Using a meaningful public process, the Oregon Health Authority shall develop...a global budgeting process for determining payments to CCOs and for revising required outcomes with any changes to global budgets.**

CCO global budgets are designed to cover the broadest range of funded services for the most beneficiaries possible. The construction of global budgets start with the assumption that all Medicaid funding associated with a CCO’s enrolled population is included. Global budgets should include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources towards the most efficient forms of care.

Once CCOs are phased in, quality incentives will be incorporated into the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

CCO global budgets will be comprised of two major components: capitated and non-capitated. The capitated portion will include funding for all services that can be disbursed to CCOs in a prospective per member per month payment. Initially, the capitated portion should include all services currently provided by physical health, mental health, and, by 2014 if not before, dental care organizations. The non-capitated portion of the global budget calculation will be for programs and services that are currently provided outside of managed care. The CCO will receive payment and be accountable for the provision of those services.

This approach provides a flexible format that recognizes that not all current Medicaid funding lends itself neatly to a per member per month calculation. As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

<b>Primary Components of the CCO global budgets and shared accountability arrangements:</b>		
<b>Medicaid Services currently capitated under managed care</b>	<b>Medicaid services <u>not</u> currently capitated under managed care</b>	<b>Exclusions from CCO Global Budgets</b>
Physical health services	Physical health services	Long term care services
+ Mental health services	+ Mental health services	+ Mental health drugs
+ Oral health services (if included)	+ Medicaid funded public health services	+ Services postponed from inclusion
<i>Per member per month capitated payment</i>	<i>Non-capitated portion; payment basis may vary</i>	<i>Shared accountability for outcomes and costs may be possible.</i>

**CCO Global Budget**

### ***Populations Included in Global Budget Calculations***

With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. An overview of the eligible CCO populations and their current managed care enrollment can be found in Appendix E. Approximately, 78 percent of people who are eligible for Medicaid are enrolled in a capitated physical health plan, 88 percent in a mental health organization, and 90 percent in a dental care organization.<sup>10</sup> HB 3650 directs OHA to enroll as many of the remaining eligible individuals (who are currently in fee-for-service) into a CCO as possible. Section 28 of HB 3650 specifically exempts American Indians, Alaska Natives and related groups from mandatory enrollment in CCOs.

### ***Service/Program Inclusion and Alignment***

One of the primary goals of the global budget concept is to allow CCOs flexibility to invest in care that may decrease costs and achieve better outcomes. The more programs, services and funding streams that are included in CCO global budgets, the more flexibility and room for innovation exists for CCOs to provide comprehensive, person-centered care. In addition, leaving necessary care outside of the global budget creates conflicting incentives where the action of payers outside of the CCO, who have little reason to contribute to CCO efficiencies, may have undue impact on costs and outcomes within the CCO.

In considering which Medicaid funding streams should be included in the global budget, the budget will start with the presumption that all Medicaid dollars are in the global budget (with the exception of the services explicitly excluded by HB 3650.) See Appendix F for a list of the services funded by Medicaid funds. Without exception, funding and responsibility for all current services provided by managed physical and mental health organizations as well as non-emergent transportation will be included in each CCO's global budget. The services that are currently capitated under physical and mental health organizations account for approximately 80 percent of Oregon's non-long-term care Medicaid expenditures. Non-emergent transportation represents another two percent of expenditures.

Currently, five percent of Oregon's non-long-term care Medicaid expenditures are associated with payments for dental care through DCOs. Dental expenditures will be included in global budgets based on individual CCO determination, as HB 3650 allows until July 1, 2014 to incorporate these services.

With respect to the remaining 13 percent of non-long-term care Medicaid expenditures, OHPB believes exceptions to service or program inclusion in the global budgets should be minimal. However, consideration could be given to CCO requests to postpone inclusion of one or more services or programs on the grounds that their inclusion would negatively impact health outcomes by reducing available funding, access or quality. CCOs are strongly encouraged to develop strategic partnerships within their community in order to successfully manage comprehensive global budgets.

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<sup>10</sup> Citizen Alien Waived Emergent Medical (CAWEM) beneficiaries and individuals who are partially dual eligible for Medicaid and Medicare—including Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB)—are not included in this calculation.

In the case of services that are postponed or excluded from CCO global budgets, it is anticipated that CCOs will enter into shared accountability arrangements for the cost and health outcomes of these services in order to ensure that incentives are aligned in a manner that facilitates optimal coordination. HB 3650 excludes mental health drugs and long-term care services from CCO global budgets. As described in the Accountability section below, these and other exclusions from CCO global budgets weaken incentives for coordinated care, which must be addressed.

### ***Global Budget Development***

The overall global budget strategy will hold CCOs accountable for costs but not enrollment growth. This strategy suggests an overall budgeting process that builds off of the current capitation rate methodology, but also includes a broader array of Medicaid services and/or programs. CCOs' 1<sup>st</sup> year global budgets will include two Medicaid components:

- A capitated portion that includes the per member per month payments for services currently provided through the OHP physical health plans, mental health organizations and, if included, dental care organizations; and,
- An add-on component to the capitated portion for the remaining Medicaid services or programs not currently included in capitation payments.

Additionally, CCO global budgets will also include Medicare funding to blend with their Medicaid funding to care for individuals eligible for both programs. After the development of an initial baseline of quality and outcome data, OHA will develop a quality incentive component to the global budget methodology to reward CCOs for improved health care outcomes and controlling costs.

#### Capitated Portion of the Global Budget Methodology

At least initially, the capitated portion CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011-13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the community it serves.

Under this approach, potential CCOs will submit a completed Base Cost Template using internal cost data that is representative of a minimum base population. This will not be a competitive bidding process, but OHA actuaries will review the submission for completeness and soundness in order to establish a base rate. Once a base rate is established, the state actuaries will use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

More specifically, in order to establish rates, OHA will gather estimated costs that utilize the most reliable cost data from potential CCOs in order to produce a base cost while addressing actuarial soundness, CCO viability, and access to appropriate care. This cost data will indicate the lowest rate a CCO can accept in their "base region," based on current population, geographic coverage and benefit package (the "CCO Base Cost Template" referenced above). OHA will use the CCO Base Cost Template as the foundation for the CCO capitation rates. If CCOs propose to operate in geographic areas where they

have little or no experience, state actuaries will use a population-based risk adjustment methodology based on the currently used Chronic Illness and Disability Payment System (CDPS), to develop the rates in these new areas.

It is anticipated that initial CCO global budget amounts be established for one year, but that stakeholders and OHA will explore the possibility of establishing global budgets that could be enacted on a biennial or multi-year basis thereafter. For subsequent years, stakeholders have indicated support for continuing to adjust payments to CCOs based on member risk profiles under the current CDPS process. Stakeholders have encouraged OHA to investigate the possibility of including pharmacy data and expanded demographic data into CDPS.

Pending direction and approval by the Legislature during the February 2012 session, it is expected that OHA carry out the following process for prospective CCOs (see Section 9 of this document for a timeline):

- Finalize CCO definition/scope and process
- Release CCO estimated cost submission process document
- Collect comments on estimated cost submission process document
- Make final changes to estimated cost submission process
- Release of CCO base cost template
- Release Notice of Intent to contract as CCO
- Collect base cost template from prospective CCOs
- Review and certification of CCO rates
- Conduct final review of CCO capitation rates
- Submit CCO capitation rates to CMS
- Submit contracts to CCOs

CCO contractors will provide Notice of Intent to contract as a CCO followed by a submission of base costs to OHA not later than the beginning of May, 2012. OHA's Actuarial Services Unit will be available for technical assistance and work closely with potential CCOs to help them prepare and submit their base cost estimates. If a potential CCO declines to provide a base cost template, OHPB does not recommend certifying a capitation rate for the CCO or issuing the CCO a contract.

The CCOs submitted rates will be reviewed by OHA's actuary and assessed for reasonableness based on documentation that the CCO is capable of:

- Attaining identified efficiencies without endangering its financial solvency
- Providing adequate access to services for its enrollees, and
- Meet all necessary federal standards, including but not limited to explanatory notes detailing planned actions, such as initiatives to increase efficiency.

OHA's Actuary will assess actuarial soundness at the CCO and region level, and will confer with the CCO regarding any questions or issues that need to be resolved. Additional calculations may be required to ensure that CCO rates in aggregate meet the 2011-13 legislatively approved budget.

#### Non-capitated or "supplemental" portion of the Global Budget Methodology

As previously stated, the OHPB recommended approach to global budgets starts with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. The non-capitated portion of the global budget calculation will encompass programs and services that are currently provided outside of managed care. The CCO will now receive payment and be accountable for the provision of those services.

However, the Board recognizes that it may not be feasible or optimal to initially wrap all Medicaid services that have been traditionally outside of managed care capitation into a per member per month payment calculation. This may be the case when communities provide the state matching funds for certain Medicaid services. New financing arrangements between the state, CCO, and county will be needed to ensure the ability to match local funds is not compromised. In other cases, there may not be adequate experience to comfortably base a per member per month calculation, at least initially.

As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

#### Blended Funding for Individuals who are Dually Eligible for Medicare and Medicaid

In HB 3650, the legislature directed OHA to seek federal waivers and permissions necessary to allow CCOs to provide Medicare and Medicaid services to individuals who are eligible for both programs. Inclusion of dually eligible enrollees in the CCOs and the associated Medicare funding in the global budget is important for a number of reasons. Medicare spending covers the majority of the costs for individuals who are dually eligible, and the vast majority of costs not associated with long-term care. Medicare is the primary payer for dual eligible beneficiaries, and therefore covers the preponderance of medical services. Including Medicare funding in the global budget creates a larger pool of funding to leverage and will allow CCOs to find economies of scope and scale. Including Medicare funding also will provide a significant opportunity to use these funding streams more flexibly and integrate care more effectively. Better coordination of care for Oregon's dually eligible population holds promise for better health and health care for them and lower Medicare and Medicaid spending.

#### Quality Incentive Payments

CCO global budget payments should be connected to quality metrics for both clinical processes and health outcomes. However, the Board recognizes such an incentive structure will be difficult to initiate in the first year of CCO operation. So initially, metrics will be utilized to ensure adequate CCO performance for all programs or funding streams in the global budget and to create a data baseline. After the initial period, metrics should be used to determine exceptional performers who would qualify for incentive rewards. The Board supports Oregon's discussions with CMS on developing an incentive program as early as possible and is following the progress of the Massachusetts Blue Cross/Blue Shield

Alternative Quality Contract and other new incentive models such as the Five-Star Quality Rating for Medicare Advantage plans to garner lessons that may be applied to CCO global budget development. The Board has emphasized that any incentive design should include shared savings approaches so that CCOs are not penalized for successfully lowering costs.

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## 7. Accountability

### ***OHA's Accountability in Supporting the Success of CCOs***

OHA will be an active partner in health care transformation and support CCOs by:

- Providing accurate and timely data and feedback to CCOs.
- Implementing and supporting learning collaboratives in partnership with CCOs, as required by HB 3650.
- Identifying and sharing information on evidence-based best practices, emerging best practices and innovative strategies in all areas of health care transformation including patient engagement and activation.
- Providing technical assistance to CCOs to develop and share their own best practice approaches. OHA should develop a system to monitor the development of best practices and the accumulation of evidence supporting new practices or innovations and should then support widespread adoption of the innovations or best practices.
- Reducing and streamlining administrative requirements.

Further, HB 3650 requires that OHA report back to the Legislature regularly on the progress of payment reform and delivery system change. It further directs OHA to publish data on quality, costs and outcomes at the CCO level.

- ***Sec 2(3)(b) The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including:***
  - a) The achievement of benchmarks;***
  - b) Progress toward eliminating health disparities;***
  - c) Results of evaluations;***
  - d) Rules adopted;***
  - e) Customer satisfaction;***
  - f) Use of patient centered primary care homes;***
  - g) The involvement of local governments in governance and service delivery; and***
  - h) Other developments with respect to coordinated care organizations.***
- ***Section 10(2) The authority shall evaluate on a regular and ongoing basis key quality measures, including health status, experience of care and patient activation, along with key demographic variables including race and ethnicity, for members in each coordinated care organization and for members statewide.***
- ***Section 10(3) Quality measures identified by the authority under this section must be consistent with existing state and national quality measures. The authority shall utilize available data systems for reporting and take actions to eliminate any redundant reporting or reporting of limited value.***
- ***Section 10(4) The authority shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, by coordinated care organization:***
  - (a) Quality measures;***
  - (b) Costs;***

***(c) Outcomes; and***

***(d) Other information, as specified by the contract between the coordinated care organization and the authority, that is necessary for the authority, members and the public to evaluate the value of health services delivered by a coordinated care organization.***

### **CCO Accountability**

- ***Section 10(1) The Oregon Health Authority through a public process shall identify objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCO contracts to hold the organizations accountable for performance and customer satisfaction requirements.***

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality, and efficiency measures identified by OHA through a robust public process and in collaboration with stakeholders. CCO accountability metrics will function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

Accountability measures for CCOs will build on OHPB committee work over the past two years, beginning with the Incentives & Outcomes Committee and followed by the Outcomes, Quality, and Efficiency Metrics Workgroup. The next stage of metrics development will be for OHA to establish a technical advisory group of experts from health plans, health systems and to include consumers to build measure specifications, including data sources, and to finalize a reporting schedule. This stage of the work will be completed by May 2012. Further technical work, such as establishing benchmarks based on initial data, will follow as outlined below.

#### Measurement and reporting requirements

Accountability measures for CCOs should be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. Staging of accountability reporting requirements should follow a consistent schedule based on the effective date of each CCO's contract, such as:

- 0-6 months – capacity development
- 6 months - first measurement period begins
- 18 months – first report date

Depending on the measure and data source, reports may flow from CCOs to OHA or the reverse. For example, it may be advantageous for OHA to collect member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs. While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, OHA will assess performance more frequently (e.g. quarterly) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

### Accountability standards, monitoring and oversight

It is expected that with the assistance of a technical advisory workgroup, OHA will establish two levels of CCO performance standards: minimum expectations for accountability and targets for outstanding performance. Performance relative to targets will affect CCOs' eligibility for financial and non-financial rewards. CCOs' performance with respect to minimum expectations relates to accountability; subpar performance will lead to progressive remediation building on current accountability mechanisms for MCOs including technical assistance, corrective action plans, financial and non-financial sanctions, and ultimately, non-renewal of contracts. (See OHA Monitoring and Oversight in the next section.) CCOs will be expected to assess their performance, to develop quality improvement plans and goals, and to demonstrate progress toward those goals over time. However, OHA will facilitate the provision of technical assistance to assist CCOs to improve their performance with respect to accountability metrics.

As with the reporting expectations, accountability standards will be introduced over time, e.g.:

- First reporting period - performance reporting without budgetary or contractual consequences
- Second reporting period – expectation of improvement if performance is below standards
- Third reporting period - measurement against benchmarks for minimum and outstanding performance

OHA will establish a technical advisory group made up of individuals with health quality measurement expertise and use data from CCOs' first reporting period to establish baselines. Further, the technical advisory group will set standards (or benchmarks) for both minimum and outstanding performance using those baselines.

### Specific areas of CCO accountability metrics

Based on input from OHPB-sponsored stakeholder work groups, CCO metrics will include both core and transformational measures of quality and outcomes:

- Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. They will be uniform across CCOs and will encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).
- Transformational metrics will assess CCOs' progress toward the broad goals of health systems transformation and will therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners. Minimum performance expectations should not apply to transformational measures but improvement or exceptional performance on transformational measures may qualify CCOs for financial or non-financial rewards (see Quality Incentive Payments above). CCOs will have some choice among a menu of transformational metrics.

The initial set of CCO accountability metrics and data sources will be established in consultation with the technical group and CMS in the first half of 2012 and will focus on outcomes and system transformation.

See Appendix G for examples of potential CCO accountability metrics and an example of how accountability for transformation can be shared across the system.

Annual review of CCO accountability metrics

The Board expects that CCO accountability metrics will evolve over time based on ongoing evaluation of the metrics' appropriateness and effectiveness. OHA will establish an annual review process that ensures participation from representatives of CCOs and other stakeholders including consumers and community partners.

***Shared Accountability for Long-term Care***

Medicaid-funded long-term care services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the state, creating the possibility of misaligned incentives and cost-shifting between the CCOs and the long-term care (LTC) system. Cost-shifting is a sign that the best care for a beneficiary's needs is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTC system. Other elements of shared accountability between CCOs and the LTC system may include contractual elements such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems, through a memorandum of understanding, a contract, or other mechanism; and reporting of metrics related to better coordination between the two systems.

## 8. Financial Reporting Requirements to Ensure Against Risk of Insolvency

- ***Section 13(3) The Authority, in consultation with the Department of Consumer and Business Services shall develop a proposal for the financial reporting requirements for CCOs to be implemented under ORS 414.725(1)(c) to ensure against the organization’s risk of insolvency. The proposal must include, but need not be limited to recommendations on:***
  - a) The filing of quarterly [statements] and annual audited statements of financial position, including reserves and retrospective cash flows, and the filing of quarterly and annual statements of projected cash flows;***
  - b) Guidance for plain-language narrative explanation of the financial statements required in paragraph a) of this subsection;***
  - c) The filing by a CCO of a statement of whether the organization or another entity, such as a state or local government agency or a reinsurer, will guarantee the organization’s ultimate financial risk;***
  - d) The disclosure of a CCO’s holdings of real property and its 20 largest investment holdings, if any;***
  - e) The disclosure by category of administrative expenses related to the provision of health services under the CCO’s contract with the authority;***
  - f) The disclosure of the three highest executive salary and benefit packages of each CCO;***
  - g) The process by which a CCO will be evaluated or audited for financial soundness and stability and the organization’s ability to accept financial risk under its contracts, which process may include the use of employed or retained actuaries;***
  - h) A description of how the required statements and the final results of evaluations and audits will be made available to the public over the Internet at no cost to the public;***
  - i) A range of sanctions that may be imposed on a CCO deemed to be financially unsound and the process for determining the sanctions, and;***
  - j) Whether a new category of license should be created for CCOs recognizing their unique role but avoiding duplicative requirements by Department of Consumer and Business Services (DCBS).***

OHA will collaborate with DCBS, as required by HB 3650, to review CCO financial reports and evaluate financial solvency. HB 3650 specifies that CCOs should not be required to file financial reports with both OHA and DCBS; DCBS will be the recipient of these reporting requirements. The following section provides an overview of proposed requirements related to the above items and addresses additional information on organizational structure, corporate status and structure, existing contracts and books of business, and risk management capacities that CCOs shall report.

### ***Audited Statements of Financial Position and Guarantees of Ultimate Financial Risk***

The Department of Consumer and Business Services defines the purpose of financial regulations of insurers as being to:

“[E]nsure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the

initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of \$2.5 million of capital and surplus for an insurer to be authorized to transact insurance. This floor increases as the company assumes more insurance risk. Capital and surplus is the amount a company's assets exceed liabilities." "Health Insurance in Oregon," DCBS; January 2009; p8

CCOs will submit financial information consistent with that required for insurers, including the use of statutory accounting principles (SAP). Application of these principles would allow for standardization of accountability and solvency assurances across health plans enrolling Medicaid, Medicare, and commercial populations and will address the CMS's interest in having organizations that enroll Medicare beneficiaries regulated by the state's Insurance Division. The filing requirements include: quarterly and annual statements of financial position using the form developed by the National Association of Insurance Commissioners (NAIC); annual actuarial certification of unpaid claim reserves, annual calculation of risk-based capital; and annual audited financial statements (using SAP). Included in the NAIC form is a schedule of retrospective cash flows and quarterly and annual statements of projected cash flows. A plain language narrative explanation of the required statements of financial position and statements of projected cash flow will be developed and made publicly available as required by statute (HB 3650 Section 13(3)(b)).

A key element for monitoring financial solvency is an understanding of a CCO's relationship and transactions with its parent, subsidiaries and affiliates. CCOs will be required to submit holding company information consistent with that required for insurers. Such information would include description of any management, service or cost-sharing arrangements and an annual consolidated audited financial statement.

### ***Financial Solvency***

It is expected that information from the NAIC financial reports will be used by financial analysts from DCBS and the Division of Medical Assistance Programs and by OHA's Actuarial Services Unit to track the financial solvency of CCOs as they gain (or lose) enrollment over time and build their financial reserves and other risk management measures commensurately. In addition, CCOs will be subject to periodic on-site financial examinations consistent with those performed on insurers. The factors below have been identified as gauges of a CCO's financial solvency; final financial reporting and solvency terms will be negotiated with CMS, which will participate regarding inclusion of Medicare funding for individuals who are dually eligible:

- *Risk-bearing entity*: As required by HB 3650, the CCO will identify whether the CCO itself or some other entity (such as a state or local government agency, or a reinsurer) will guarantee the CCO's ultimate financial risk, in full or in part. In some cases, CCOs may enter into contracts with hospitals, physician groups, or other providers to share in the financial risk (and rewards) associated with the difference between targeted or projected expenditures and actual expenditures. The extent to which these arrangements reduce the risk borne by the CCO itself will be factored into an actuary's determination of the CCO's reserves.

- *Reinsurance*: Provided through the state or purchased individually by CCOs, reinsurance will act to limit the financial risk of the CCO by capping its risk exposure on either a case-by-case or aggregate basis.
- *Claims reserves*: An adequate amount of liquid assets to satisfy claims liability is required of health plans providing commercial, Medicare, and Medicaid coverage in Oregon. Claims reserve requirements for CCOs will be actuarially determined to reflect the CCO's enrollment level and its mix of covered lives based on rate category.
  - *Medical loss ratio*: This is the ratio of expenditures (or claims) incurred for the provision of health care services divided by total health care service revenue (. Expenditures incurred for health care services is the amount paid plus the change in the unpaid claim liability. The unpaid claim liability is an estimate for claims already reported but not yet paid and an estimate of the claims for health care services used by a member that have not yet been submitted for payment.
  - *Size of the organization and risk characteristics*: Total number of insured lives and the risk characteristics across all lines of business will be considered ("risk-based capital").
  - *Enrollment level*: The predictability of CCO expenditures and the ability of the CCO to bear risk are reduced at lower enrollment levels. CMS currently requires that Medicare Advantage Plans have a minimum enrollment level of 5,000 beneficiaries. OHPB recommends that CCOs be required to file their actual and projected enrollment levels, by rate category.
  - *Organizational liability*: As required by HB 3650, CCOs will be required to file a statement identifying the entity that will be the guarantor of the CCO's ultimate financial risk and any other entities or persons sharing in that risk (in addition to identifying contracting providers bound by risk sharing agreements with the CCO).
  - *Real property, investments, and executive compensation*: As required by HB 3650, each CCO will be required to disclose their real property holdings, their 20 largest investment holdings, and executive compensation. The NAIC form for annual statements includes schedules that provide details on each of these items.
  - *Operating budget*: As described below, OHPB recommends that each CCO be required to describe an annual operating budget including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting any alternative payment methodologies implemented. This operating budget will serve both to indicate the financial soundness of the CCO and to demonstrate that the CCO has developed its budget to reflect the requirements and objectives of health systems transformation.
  - *Administrative expenses*: As required by HB 3650, each CCO will be required to outline, by category, administrative expenses relating to provision of services under its CCO contract. The NAIC form for annual statements includes a schedule of expenses by expense category. The expense schedule would show CCO expenses for all of its populations - those incurred under its CCO contract as well as contracts for other populations including Medicare, PEBB, OEBC, and other commercial insurance. Other schedules and note disclosures required by the NAIC form will provide information about expense arrangements with a parent or affiliate organization and detail amounts paid for such service arrangements. A comprehensive understanding of CCO

administrative expenses will make possible a more accurate evaluation of the CCO's overall sustainability.

### ***OHA Monitoring and Oversight***

OHA must work in partnership with CCOs to ensure health system transformation success. OHA will institute a system of progressive accountability that maximizes the opportunity to succeed but also protects the public interest. Actions taken when access, quality or financial performance are jeopardizing members should be aligned with the categories that currently exist with DCBS. These categories reflect that OHA would become increasingly involved over time if an entity continues to miss performance guidelines with increased monitoring, technical assistance and supervision.

#### Quality, access and financial monitoring

Measures for monitoring and oversight in these areas should be aimed initially at root cause analysis and assisting the CCO in developing improvement strategies. Steps taken should be progressive, building on current accountability mechanism for MCOs, and may include:

- Technical assistance to identify root causes and strategies to improve
- Increased frequency of monitoring efforts
- Corrective action plan
- Restricting enrollment
- Financial penalties
- Non-renewal of contracts

Conversely, OHA may choose to offer a simplified, streamlined recertification or contracting process to high performing CCOs, in addition to the possibility of financial performance incentives,.

#### Monitoring of financial solvency

If a CCO's financial solvency is in jeopardy, OHA and DCBS will act as necessary to protect the public interest. These measures have two objectives: first, to restore financial solvency as expeditiously as possible; and second, to identify the causes of the threat to solvency and implement measures to prevent such threats in the future. Actions may include:

- Increased reinsurance requirements
- Increased reserve requirements
- Market conduct constraints
- Financial examinations

The ultimate action, if no effective remedy is feasible, will be loss of licensure and liquidation of assets as necessary to meet financial obligations.

### ***Public Disclosure of Information***

Current DCBS rules require the public disclosure of information pertaining to licensed insurers. It is anticipated that these rules will also apply to CCOs.

### ***CCO Licensure***

A new licensure category will be created for CCOs by DCBS in collaboration with OHA. This new licensure category will reflect the unique requirements and objectives of health systems transformation. This will also allow the application of certain insurance code provisions to CCOs that will allow for consistency of reporting and financial solvency and comparability among CCOs and insurers but will not subject CCOs to insurance code provisions that are not necessary given their unique contracting relationship with OHA. A separate licensure category will also facilitate the blend of flexibility and accountability that will be needed for successful implementation and operation of CCOs. DCBS and OHA staff will determine whether statutory changes are required to implement a licensure category specific to CCOs, and propose such changes through the 2012 legislative process. In the interim, existing licensure categories will be used as appropriate to the populations covered.

CCOs will be expected to provide information on corporate status, participation in the Oregon Health Plan, and other contracts:

- Corporate status: where incorporated; affiliated corporate entity or entities involved under potential CCO contract; current Department of Consumer and Business Services (DCBS) licensure/certification
- Oregon Health Plan MCO or MHO status: current OHA MCO or MHO contractor status; organizational changes involved in CCO application; whether CCO is formed through MCO or MHO partnership; and MCO or MHO service area vs. CCO service area
- Other state contracts: Oregon Medical Insurance Pool (OMIP); Healthy Kids/Kids Connect; PEBS; OEBS
- Medicare contracts: CMS contracts with CCO to provide Medicare services
- Commercial contracts: both group and individual markets
- Administrative services or other management contracts

### ***Corporate Assets and Financial Management***

As part of the certification process, CCOs will provide information relating to assets and financial and risk management capabilities, including:

- Tangible net equity and other assets
- Risk reserves, current and scheduled based on enrollment and projected utilization
- Risk management measures
- Delegated Risk
- Reinsurance and Stop Loss
- Incurred but not reported (IBNR) tracking
- Claims payment
- Participation in the All Payer All Claims reporting program as required by Section 4(k)(L)

- Internal auditing and financial performance monitoring
- Administrative cost allocation across books of business (including Medicaid, Medicare, and commercial)

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## 9. Implementation Plan

### ***Transition Strategy***

In addition to accommodation through appropriate levels of flexibility, incentives to form CCOs as early as possible should be integrated into the CCO certification process. OHPB recommendations for such incentives include, but are not limited to, the following options:

- *Financial incentives:* Global budget adjustments, annual trend rates, and incentive payments or enhanced federal financial payments, if available, could be structured to support CCOs, providing financial incentives to form the new organization early. This approach provides not only strong incentives and resources for CCOs, but also underscores the urgency and priority of health system transformation.
- *Enrollment incentives:* Building up sufficient enrollment to mitigate risk is essential for CCO start-up. New eligibles and those due for annual redetermination should be automatically enrolled in CCOs. This strategy will need to take in to account the choice and notification of enrollees, including those eligible for both Medicare and Medicaid.
- *Flexibility incentives:* Efforts to provide flexibility in service delivery and administration should be directed first and foremost to CCOs.
- *Technical assistance and training incentives:* CCOs will benefit from the learning collaborative that OHA will establish, as required by HB 3650, and from state-level work to accumulate evidence about and disseminate information on innovative service delivery practices. If OHA successfully applies for and receives enhanced federal financial contributions for workforce training, then these funds would also be made available to CCOs that invest in developing the alternative workforce identified in HB 3650 including community health workers, peer wellness specialists, and personal health navigators.

### ***Transitional Provisions in HB 3650***

In the case of an area of the state where a CCO has not been certified, Sections 13 and 14 of HB 3650 require continued contracting with one or more prepaid managed care health services organizations in good standing and already serving that area. In addition, HB 3650 requires these organizations to fulfill a substantial portion of CCO responsibilities including specific service offerings, organizational structure, patient-centered primary care homes and other system delivery reforms, consumer protections, and quality measures. Continued contracting with prepaid managed care health services organizations will reflect these statutory requirements. MCO contracts will be amended to reflect the requirements of HB 3650 in parallel to the certification process for CCOs.

### ***Implementation Timeline***

The sequence below indicates key timeframes for MCOs and MHOs transitioning to CCO status (dates are approximate and subject to legislative and CMS approval):

#### Rules:

March 2012

OHA will release temporary administrative rules defining CCO criteria and other administrative rule changes as necessary

June-Sept 2012 OHA administrative rules process to finalize CCO/MCO changes that includes the required Rules Advisory Committee

CCO Applications:

March 2012 OHA will release CCO application, with Letter of Intent  
April 2012 CCO applicants will submit applications to demonstrate that they meet CCO criteria to OHA  
April-May 2012 OHA will evaluate CCO applications  
June 2012 OHA will certify CCOs (CMS will approve CCOs for enrollment of dually eligible)

Contracts:

March 2012 CCO estimated cost submission process defined (including public comment process) and release of CCO Base Cost template  
April 2012 CCO applicants will submit notices of intent to contract and, subsequently, base cost estimates  
April –June 2012 State to negotiate CCO contracts and budget (CMS will participate regarding inclusion of Medicare funding for dually eligible)  
April-May: OHA Review and Certification of CCO Rates  
May: Final Review of CCO budget  
June: CCO budget Submitted to CMS  
June: Contract to CCO  
July 1: Effective date of CCO Contract  
July 31: 3-way contracts signed between CCO/state/CMS (may come behind OHA contracts, as a contract amendment or rider)

Implementation:

June-August 2012 State and CMS conduct “readiness review” of certified CCOs for inclusion of the dually eligible (CMS will participate regarding inclusion of Medicare funding for dually eligible)  
July-September 2012 CCOs passing Medicare “readiness review” can begin preparing for enrolling dually eligible individuals for Medicare services  
July 2012 First CCOs enroll Medicaid beneficiaries  
July 2012 HB 3650 Sections 4, 6, 8, 10, and 12 take effect for MCOs  
September 30, 2012 Current MCO contracts due for renewal  
January 2013 CCOs begin providing Medicare services to dually eligible beneficiaries

## 10. Appendices

- A. Managed care plan types and service areas
- B. Financial projections and potential savings tables (*forthcoming*)
- C. Proposed Alternative Dispute Resolution (ADR) process
- D. CCO Criteria Matrix (criteria detail)
- E. Table of eligibles for CCO enrollment and current managed care enrollment status
- F. Program List
- G. Accountability framework and example metrics

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# **CCO Implementation Proposal**

## **Appendices A; C-G**

**January 10, 2012**



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## Appendix A: Current Managed Care Plans and Service Areas

### Fully Capitated Health Plans (FCHP) and Physician Care Organizations (PCO)

Plan	Organization Type	Counties Served
Care Oregon, Inc.	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Yamhill, Washington
Cascade Comprehensive Care, Inc.	FCHP	Clackamas, Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Linn, Malheur, Marion, Multnomah, Polk, Umatilla, Union, Wasco, Washington, Yamhill
DCIPA, LLC	FCHP	Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Tillamook, Union, Washington, Yamhill
Docs of the Coast South	FCHP	Benton, Clackamas, Coos, Curry, Deschutes, Douglas, Hood River, Jackson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Union, Washington, Yamhill
Family Care, Inc.	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
Intercommunity Health Network	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Harney, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
Kaiser Permanente or Plus, LLC	PCO	Baker, Clackamas, Clatsop, Columbia, Coos, Deschutes, Douglas, Jackson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Sherman, Umatilla, Wasco, Washington, Yamhill
Lane Individual Practice Association	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Washington, Yamhill
Marion Polk Community	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Sherman, Tillamook, Umatilla, Wallowa, Wasco, Washington, Yamhill
Mid-Rogue Holding Company	FCHP	Baker, Benton, Clackamas, Coos, Crook, Curry, Deschutes, Douglas, Jackson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Multnomah, Umatilla, Union, Washington
ODS Community Health, Inc.	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
Oregon Health Management Services	FCHP	Benton, Clackamas, Coos, Curry, Deschutes, Douglas, Jackson, Josephine, Klamath, Lane, Linn, Marion, Multnomah, Sherman

Plan	Organization Type	Counties Served
<b>Pacific Source Community Solutions, Inc.</b>	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Providence Health Assurance</b>	FCHP	Benton, Clackamas, Clatsop, Columbia, Coos, Deschutes, Gilliam, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Marion, Multnomah, Polk, Sherman, Tillamook, Wasco, Washington, Yamhill
<b>Tuality Health Alliance</b>	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Deschutes, Douglas, Harney, Jackson, Josephine, Lane, Lincoln, Marion, Multnomah, Polk, Tillamook, Washington, Yamhill

### Mental Health Organizations (MHO) and Dental Care Organizations (DCO)

Plan	Organization Type	Counties Served
<b>Access Dental Plan, LLC</b>	DCO	Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Deschutes, Douglas, Gilliam, Grant, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
<b>Accountable Behavioral Health</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Advantage Dental</b>	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Capitol Dental Care, Inc.</b>	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Clackamas Mental Health Organization</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Family Care, Inc.</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Family Dental Care</b>	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Hood River, Jackson, Jefferson,

Plan	Organization Type	Counties Served
<b>Greater Oregon Behavioral Health, Inc.</b>	MHO	Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Sherman, Tillamook, Union, Washington, Yamhill Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Jefferson Behavioral Health</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
<b>Lane Care</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Managed Dental Care of Oregon</b>	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
<b>Mid Valley Behavioral Care Network</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
<b>Multicare Dental</b>	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
<b>Multnomah Verity</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>ODS Community Health, Inc.</b>	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
<b>Pacific Source Community Solutions, Inc.</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
<b>Washington County Department of Mental Health</b>	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco,

Plan	Organization Type	Counties Served
<b>Willamette Dental Group</b>	DCO	Washington, Yamhill Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill

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## APPENDIX C

### Introduction to Dispute Resolution Process Outline

**HB 3650** required the development of a process that involves the use of an independent third party arbitrator to resolve disputes when a necessary health care entity (HCE) refuses to contract with an organization seeking to form a coordinated care organization (CCO). The process must be presented to the Legislative Assembly for approval. This outline was developed by OHA, with input from an external stakeholder work group.

**HB 3650 Section 8(4) – (7)** provides as follows:

(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.

(5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.

(6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.

(7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.

**Scope:** Section 4 shows that this statutory process applies when an organization is seeking to form a CCO and participation by a health care entity (HCE) is necessary for the organization to qualify as a CCO. As a result, the proposed process is limited to the certification of CCOs and only when the HCE is necessary for the organization to qualify as a CCO. This limited scope is also consistent with the substantial statutory remedy in subsection (6) for an unreasonable refusal to contract by an HCE.

**Who is qualified to serve as an arbitrator?** Statute is silent about who is qualified to serve as an arbitrator in this process, except to require the “use of an independent third party arbitrator.” OHA recommends that the CCO applicant and the HCE use any qualified independent third party arbitrator that they agree upon. The proposed process provides some minimal recommendations for the qualifications of the arbitrator. The arbitrator must:

- Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
- Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650

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**Length of time for arbitration process:** Since Section 8 establishes this arbitration process when an organization is seeking to become qualified as a CCO, a dispute with a necessary HCE should be resolved promptly. A timeline of 60 calendar days is recommended once an arbitration process is initiated by one of the parties. Extending the time should require the written agreement of both parties.

#### **PROCESS FOR RESOLVING DISPUTES UNDER SECTION 8(4) - (7)**

**Preliminary good faith negotiations: GOAL – the parties voluntarily agree on terms and enter into contracts**

1. Organization is seeking to become certified as a CCO ( Applicant) and:
  - a. Applicant asserts that a health care entity (HCE) is necessary for Applicant to qualify as a CCO;
  - b. An HCE asserts that its inclusion is necessary for Applicant to be certified as CCO; or
  - c. OHA, in reviewing Applicant information, identifies the HCE as necessary for Applicant to qualify as CCO.
2. If there is disagreement between an Applicant and HCE regarding whether the HCE is “necessary”, the Applicant or HCE can request review from OHA about whether the HCE may be considered “necessary” for an Applicant to qualify as a CCO.
  - a. If the specific HCE is deemed by OHA as not “necessary” for Applicant to be certified as a CCO, then this specific process does not apply per Section 8.
  - b. The process described below only applies where an HCE is deemed by OHA as “necessary” for the Applicant to be certified as a CCO (or the parties agree that the HCE is “necessary” for an Applicant to qualify as a CCO), in accordance with Section 8.
3. If deemed by OHA as “necessary” or the parties agree that the HCE is “necessary”, the HCE and Applicant participate in contract negotiations.
  - a. Goal: Applicant and HCE agree on terms and enter into a contract.
4. Request for technical assistance from OHA – voluntary.
  - a. Either Applicant or HCE may request OHA technical assistance.
  - b. OHA may offer technical assistance. OHA assistance will be confined to clarification of the CCO certification process and criteria, and other program requirements.
5. Before requesting referral to this dispute resolution process, the parties should take the following actions in an attempt to reach a good faith resolution between the Applicant and the HCE:
  - a. The Applicant has provided a written offer of terms and conditions to the HCE and the HCE has explained to the Applicant the source of disagreement, if any.
  - b. Before referral, the CFO or CEO of each organization have had at least one face-to-face meeting in a good faith effort to resolve the source of disagreement.
  - c. Goal: Applicant and HCE agree on terms and enter into a contract.

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6. If the Applicant and HCE are unable to reach agreement on contract terms within 10 calendar days of the HCE and Applicant face-to-face meeting in 5(b), either party can notify the other party in writing to initiate referral to an independent third party arbitrator. (At that time, the party initiating the referral will provide a copy of the notification to the OHA.) The arbitrator must:
  - a. Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
  - b. Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650.

**Arbitration Process – NOTE: At any point in this process, the CCO and HCE can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.**

1. After notification that arbitration is being initiated, the parties agree upon the arbitrator and complete paperwork required to secure the arbitrator’s services – costs for arbitration to be borne by the parties. (Estimated 15 calendar days) NOTE: Any changes to the time periods described in this process requires the written agreement of both parties.
2. Once referral is completed (step 1), the Applicant and HCE have 10 days to submit to each other and the arbitrator their most reasonable contract offer (10 calendar days) or submit a statement from the HCE that no contract is desired and why this is reasonable.
3. The parties then have 10 days from receipt of the other party’s offer, or HCE statement that no contract is desired, to submit to the arbitrator and the other party their advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the Applicant. (10 calendar days)
  - a. Legal standards for arbitration:
    - i. A HCE may reasonably “refuse to contract with a CCO if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service” – per Section 8(5)  
NOTE: Where statute establishes particular reimbursement requirement (e.g., Type A and B hospitals, federally qualified health centers, rural health centers, providers of Indian health services), those laws shall govern the determination of reasonable cost.
    - ii. Except as provided in (i), a HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the legislative policies described in Sections 1 – 4 of HB 3650. Some examples of facts or circumstances pertinent to what is “unreasonable” includes but are not limited to:
      1. Whether participation in the CCO contract imposes demands on the HCE that the HCE cannot reasonably meet without negative impact on HCE costs in the context of the proposed reimbursement arrangement,

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including but not limited to use of electronic health records, service delivery requirements, or quality or performance requirements.

2. Whether refusal to contract by the HCE impacts access to covered services in the community that should be provided by the CCO. This factor alone should not be used to find a refusal to contract unreasonable, but it is recognized that HCEs and CCOs should be encouraged to make a good faith effort to work out differences in order to achieve beneficial community objectives and the policy objectives of HB 3650
4. Arbitrator determination and final opportunity to settle:
    - a. The arbitrator must evaluate the final offers/statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' arguments about whether the refusal to contract is reasonable or unreasonable. (15 calendar days)
    - b. The arbitrator's determination will be provided to the parties and not disclosed publicly to the OHA for a period of 10 calendar days, to allow the parties an opportunity to resolve the contract issue themselves. (10 calendar days)
    - c. If the parties have not voluntarily reached an agreement regarding contract terms after the 10 day period, the arbitrator's decision must be released to the OHA. Once released to OHA, the arbitrator's decision will be a public record, subject to protection of trade secret information if identified by one of the parties prior to submission to OHA. (Total time = 60 calendar days)

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

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
<p><b><u>Governance Structure:</u></b>  <b>Each CCO has a governance structure that includes:</b></p> <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</li> <li>• the community at large, to ensure that the organization's decision-making is consistent with the values of the members of the community</li> </ul>	<p>CCO clearly articulates:</p> <ul style="list-style-type: none"> <li>• 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, and</li> <li>• How the governing board makeup reflects community needs and supports the goals of health care transformation.</li> </ul>		<ul style="list-style-type: none"> <li>• Feedback from the Community Advisory Council</li> <li>• Member experience or satisfaction surveys</li> </ul>	
<p><b><u>Community Advisory Council:</u></b>  <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</b></p>	<ul style="list-style-type: none"> <li>• CCO establishes a CAC grounded in an assessment of community health needs and a process that assures the CAC reflects the diversity of the community.</li> <li>• A member of the CAC sits on the governing board</li> <li>• CCO employs best practices to support engagement and</li> </ul>	<ul style="list-style-type: none"> <li>• CCO assures collaboration between the CAC and the governing board on policy formulation and other decision-making affecting patient care and health outcomes.</li> </ul>	<ul style="list-style-type: none"> <li>• Community needs assessment results</li> <li>• Consideration of CAC recommendations in Board meeting in minutes</li> </ul>	

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
the community are being met	participation of members, including those facing barriers to participation.			
<b><u>Nonprofit Agencies:</u></b> The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.	<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> </ul>			
<b><u>Dental Care Organizations:</u></b> On or before 7/1/14, each CCO will have a formal contractual relationship with any DCO in its service area	<ul style="list-style-type: none"> <li>• CCO has a plan for forming contractual relationships with any DCO in its serve area on or before 7/1/14.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• CCOs will need to ensure network adequacy for dental care providers; provide navigation assistance to access dental care, and make appropriate referrals for chronic diseases related to oral health issues.</li> </ul>		
<b><u>Person-centered Care:</u></b> Each member receives integrated person-centered care and services designed to provide choice, independence and dignity	<ul style="list-style-type: none"> <li>• Members should be reassessed at least annually to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.</li> </ul>		<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><u>Safeguards for Members:</u></b>	<ul style="list-style-type: none"> <li>• CCO adheres to safeguards for</li> </ul>	<ul style="list-style-type: none"> <li>• CCO adheres to safeguards</li> </ul>		

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b>CCO complies with safeguards for members as described in Section 8, Consumer and Provider Protections, of HB 3650</b></p>	<p>members as described in Section 8 of HB 3650.</p>	<p>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.</p>		
<p><b><u>Patient Engagement:</u></b>  <b>CCO operates in a manner that encourages patient engagement, activation, and accountability for the member's own health.</b></p>	<ul style="list-style-type: none"> <li>• CCOs will perform an upfront assessment of member's capacity for participating effectively in advocating and coordinating their own care.</li> <li>• CCO demonstrates how it will facilitate activation of its enrolled population, understanding to the greatest extent feasible, how the approach taken will take into consideration the social determinants of health.</li> <li>• OHA may provide a clearinghouse of best practices for CCOs and disseminate best practice information when available.</li> </ul>	<ul style="list-style-type: none"> <li>• CCO provides resources based on member's Patient Activation level (1, 2, 3 or 4).</li> <li>• CCO demonstrates they are training and engaging their providers to facilitate patient and family/caregiver's engagement.</li> </ul>	<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>	
<p><b><u>Member Access and Provider Responsibilities:</u></b>  <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</b></li> </ul>	<ul style="list-style-type: none"> <li>• CCOs must ensure that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions.</li> <li>• Ensure access to primary care where screenings can occur to determine if a higher level of care is needed.</li> </ul>	<ul style="list-style-type: none"> <li>• CCOs will ensure a breadth of providers capable of providing services across the continuum of care with a multidisciplinary, holistic and team approach.</li> </ul>	<ul style="list-style-type: none"> <li>• Community needs assessment results</li> </ul>	

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b>members</b></p> <ul style="list-style-type: none"> <li>• are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history</li> <li>• emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication</li> <li>• are permitted to participate in networks of multiple CCOs</li> <li>• include providers of specialty care</li> <li>• are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards</li> <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>	<ul style="list-style-type: none"> <li>• Ensure providers are working at the top of their license.</li> </ul>			
<p><b>Member and Care Team:</b> Each member has a consistent and stable relationship with a care team that is responsible for providing</p>	<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</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</li> </ul>	<ul style="list-style-type: none"> <li>• % of members in a PCPCH</li> <li>• % of PCPCHs certified as Tier 3 (highest level)</li> <li>• A delivery system network</li> </ul>	

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Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b>preventive and primary care, and for comprehensive care management in all settings</b></p>	<p>according to Oregon's standards.</p> <ul style="list-style-type: none"> <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>	<p>those PCPCHs will be moving toward Tier 2 and 3 of the Standards.</p> <ul style="list-style-type: none"> <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>	<p>plan that includes network development activities, on-going management, and technical assistance for providers.</p> <ul style="list-style-type: none"> <li>• Data that identify utilization by provider type with a plan to address shifts in care within the delivery system.</li> </ul>	
<p><b><u>Holistic Care through Primary Care Homes:</u></b>  <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></p>	<ul style="list-style-type: none"> <li>• CCO develops a process to conduct health screenings for members to assess individual care needs.</li> <li>• Each member shall have an individual care plan for physical and behavioral health care needs, inclusive of social support needs (e.g., community resources and housing). Individual care plans shall consider specific treatment plans from all providers.</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>	
<p><b><u>Transitional Care:</u></b>  <b>Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long term care setting</b></p>	<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> </ul>	<ul style="list-style-type: none"> <li>• 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</li> </ul>	<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</li> </ul>	

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
		treatment planning. Tracking system may include appropriate follow-up guidelines, alerts, and reporting.	questionnaire measuring quality of patient preparation for transitions (understanding own role; medication reconciliation; incorporation of personal preferences into care plan)	
<b><u>Navigating the System:</u></b> <b>Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, community health workers and personal health navigators who meet competency standards established by the Authority</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 facilitates appropriate linkages to state and local government agencies and community and social support service organizations to capitalize on available resources for different members' needs.</li> </ul>	<ul style="list-style-type: none"> <li>• All CCO members have full support in navigating the health care system and in accessing the full range of services and supports available through state and local government and other community and social support services that may be provided by both traditional and non-traditional health workers.</li> </ul>	<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 needs</li> </ul>	
<b><u>Accessibility:</u></b> <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>	<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> </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>		

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Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b><u>High Need Members:</u></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</p>	<ul style="list-style-type: none"> <li>• A substantial percentage of high risk members have an individualized care plan.</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>	
<p><b><u>Learning Collaborative:</u></b>                      Each CCO participates in the learning collaborative described in ORS 442.210</p>	<ul style="list-style-type: none"> <li>• 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, state and local government, and community and social support services.</li> </ul>			
<p><b><u>Patient Centered Primary Care Homes:</u></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</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> </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>	

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Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b>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 requires their other contracting health and services providers to communicate and coordinate with the PCPCP in a timely manner using electronic health information technology, where available.</li> </ul>			
<p><b><u>Health Equity:</u></b>  <b>Health care services...focus on...improving health equity and reducing health disparities</b></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• 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 inequities over time.</li> </ul>	<ul style="list-style-type: none"> <li>• CCO demonstrates meaningful and systematic engagement with critical populations in its community to create and implement plans for addressing health equity and health disparities.</li> </ul>	<ul style="list-style-type: none"> <li>• Community needs assessment results</li> <li>• A comprehensive community oriented health equity plan.</li> </ul>	
	<ul style="list-style-type: none"> <li>• 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 disease management, care coordination, provider communication, etc.) and how they will ensure cultural competence.</li> </ul>	<ul style="list-style-type: none"> <li>• 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, and other factors.</li> </ul>	<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>	
<p><b><u>Alternative Payment Methodologies:</u></b>  <b>OHA encourage CCOs to use alternative payment methodologies</b></p>	<ul style="list-style-type: none"> <li>• CCOs will need to move from a predominantly fee-for-service system to alternative payment methods that base reimbursement</li> </ul>	<ul style="list-style-type: none"> <li>• CCOs will effectively implement alternative payment approaches to create incentives for</li> </ul>		

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b>that:</b></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 quality care</li> <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>on the quality rather than quantity of services provided.</p>	<p>evidence-based guidelines and best practices that will be expected to increase health care quality and patient safety and result in more efficient use of health care services.</p> <ul style="list-style-type: none"> <li>• CCOs will build provider capacity to help restructure practices to be able to respond effectively to new payment incentives.</li> </ul>		
<p><b>Health Information Technology:</b>  <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 electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and develops a HIT improvement plan for meeting transformation expectations.</li> <li>• CCO participates in a Health Information Organization (HIO) or is registered with a statewide or local Direct-enabled Health Information Service Provider</li> </ul>	<ul style="list-style-type: none"> <li>• CCO providers have EHR/HIE capacity to send and receive patient information in real time, and CCOs have the analytic capacity to assess patient outcomes of care coordination.</li> </ul>	<ul style="list-style-type: none"> <li>• % providers within CCO that meet Meaningful Use criteria</li> <li>• % of CCO providers who have an EHR</li> <li>• % of e-prescriptions, electronic lab orders and clinical summaries shared electronically</li> <li>• Meeting milestones/goals of HIT improvement plan</li> </ul>	

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<p><b><u>Outcome and Quality Measures:</u></b>  <b>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</b></p>	<ul style="list-style-type: none"> <li>• CCO reports an acceptable level of performance with respect to identified metrics, following a consistent schedule based on the effective date of each CCO's contract.</li> <li>• CCO submits APAC data in a timely manner according to program specifications.</li> </ul>	<ul style="list-style-type: none"> <li>• CCO reports exceptional performance with respect to identified metrics.</li> </ul>	<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><b><u>Transparency:</u></b>  <b>CCO is transparent in reporting progress and outcomes.</b></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 available to members.</li> </ul>	<ul style="list-style-type: none"> <li>• CCO has system in place to provide timely performance and outcomes data to all stakeholders.</li> </ul>		
<p><b><u>Best Practices:</u></b>  <b>Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks</b></p>	<ul style="list-style-type: none"> <li>• CCOs will address these subjects in their applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650.</li> <li>• CCOs will establish a Clinical Advisory Panel (CAP) to ensure clinical best practices. The CAP</li> </ul>		<ul style="list-style-type: none"> <li>• Annual reports</li> </ul>	

## APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From <i>HB 3650</i>	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
	should be represented on the CCO governing board, similar to the CAC.			

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## APPENDIX E - Overview of CCO eligible populations

### Oregon Medicaid Caseload for Inclusion in Coordinated Care Organization (CCO) Global Budgets Includes Managed Care and Fee For Service

Populations Included in CCO Global Budgets	Total Eligibles	Medical		Dental		Mental Health	
		FCHP + PCO*	FFS	DCO	FFS	MHO	FFS
<b>OHP Plus (Categorical Pops)</b>	<b>362,182</b>	287,049	75,132	320,790	41,392	314,177	48,005
<b>SCHIP (ages 0-18)</b>	<b>58,473</b>	52,236	6,237	55,721	2,753	55,314	3,160
<b>OHP Standard (1115 Expansion Population)</b>	<b>46,206</b>	38,471	7,735	42,084	4,122	42,058	4,148
<b>Fully Dual Eligible</b>	<b>58,675</b>	33,967	24,709	52,080	6,595	50,532	8,143
<b>Subtotal</b>	<b>525,537</b>	<b>411,723</b>	<b>113,813</b>	<b>470,674</b>	<b>54,862</b>	<b>462,080</b>	<b>63,456</b>
<b>To Be Decided</b>							
<b>Citizen Alien Waived Emergent Medical - Prenatal</b>	<b>1,138</b>	-	1,138	-	1,138	-	1,138
<b>Citizen Alien Waived Emergent Medical</b>	<b>22,558</b>	-	22,558	-	-	-	-
<b>Breast and Cervical Cancer Program - Medical</b>	<b>444</b>	-	444	-	444	-	444
<b>Subtotal</b>	<b>24,140</b>	-	<b>24,140</b>	-	<b>1,582</b>	-	<b>1,582</b>
<b>Grand Total</b>	<b>549,677</b>	<b>411,723</b>	<b>137,954</b>	<b>470,674</b>	<b>56,445</b>	<b>462,080</b>	<b>65,039</b>

\* FCHP - Fully Capitated Health Plan  
PCO - Physician Care Organization

#### Notes:

- Medical, Dental and Mental Health eligibles should *not* be added together to reach totals. Rather, most beneficiaries are eligible for all three types of services and are therefore counted separately under each.
- OHP Plus includes: Temporary Assistance to Needy Families-Medical, Poverty Level Medical Adults, Poverty Level Medical Children, Aid to the Blind and Aid to the Disabled, Old Age Assistance, and Foster Care, Substitute or Adoptive Care Children.
- SCHIP includes ages 0 to 18, excludes CAWEM Prenatal.
- Eligibility categories do not include Family Health Insurance Assistance Program, Healthy Kids Connect, CHIP Employered-Sponsored Insurance.

#### Staff reference:

09-11 Dec Rebal; includes FFS and Managed Care.

**APPENDIX F**  
**Example List of Medicaid Services and Programs For Inclusion in**  
**CCO Global Budgets**

Medicaid Program/Services	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	
				% of Non-LTC Medicaid Spend
<b>Physical Health Programs*</b>				
Physical health coverage, including emergency transport, FCHP administrative, hospital reimbursement allowances, FQHC wraparound, and pass through.	Depending on benefit package, includes medical care from a physician, nurse practitioner or physician assistant; hospital care; hospice care; laboratory and x-ray; medical equipment and supplies; emergency medical transportation; physical, occupational and speech therapy; prescription drugs (excluding mental health drugs); vision services and other covered services.	Fully capitated health plans, Physician Care Organizations	Y	52%
		FFS Only		18%
Dental coverage, including DCO administrative**	Includes basic dental services, urgent/immediate treatment and other services.	Dental Care Organizations	Y	5%
Non-emergency medical transportation	Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation for Medicaid eligibles to access OHP covered services when no alternative transportation is available.	Transportation Brokerages & FFS		2%
Citizen Alien Waived Emergent Medical (CAWEM)	Emergency medical services to non-citizens who are eligible for medical assistance except they do not meet the Medicaid citizenship and immigration status requirements.	FFS Only		1%
Citizen Alien Waived Emergent Medical (CAWEM) Prenatal Program	Prenatal care to pregnant women who are currently only eligible for CAWEM Emergency Medical. (Only in select counties; voluntary enrollment only)	FFS Only		<1%
Breast and Cervical Cancer Program - Medical	Provides access to medical care for low-income, uninsured, and medically underserved women diagnosed with breast or cervical cancers	FFS Only		<1%
Behavioral Rehabilitation Services (Leverage)	Services provided by a child-caring agency in a shelter, residential or therapeutic foster care placement setting to remediate psychosocial, emotional and behavioral disorders.	FFS Only		<1%
Targeted Case Management (Leverage)	Assists eligible clients in gaining access and effectively using medical, social, educational, and other services.	FFS Only		<1%

\* Class 7 & 11 mental health drugs are not included in this list because House Bill 3650 excludes them from CCO global budgets. However, they are included in the total expenditures used to calculate percentages in this table.

\*\* Dental Care Organizations are not required to enter into contracts with CCOs until July 1, 2014, but may do so at an earlier date.

**APPENDIX F**  
**Example List of Medicaid Services and Programs For Inclusion in**  
**CCO Global Budgets**

Medicaid Program/Services	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?		% of Non-LTC Medicaid Spend
<b>Addictions &amp; Mental Health Programs</b>					
Mental Health Coverage including MHO administrative	Medicaid funded ambulatory assessment and treatments (based on the prioritized list) of mental health conditions provided in community-based settings by licensed practitioners or non-licensed personnel employed by agencies with a certificate of approval by OHA/AMH.	Mental Health Organizations	Y		8%
		FFS Only			1%
Adult Community Residential Mental Health Services	Mental health services provided in a residential setting.	CMHP			3%
Addiction health coverage	Ambulatory assessment and treatments (based on the prioritized list) of substance use disorders provided by licensed professionals or non-licensed personnel employed by agencies.	FCHPS and PCOs	Y		1%
		FFS Only			<1%
Adult residential alcohol and drug treatment***	Alcohol and drug treatment provided in a residential setting.	CMHP and direct contracts w/providers			<1%
Residential mental health for non-forensic children	Mental health services provided in a residential setting.	MHO plus provider direct billing to DMAP for non-MHO enrolled children	Y		<1%
Youth residential alcohol and drug treatment ***	Alcohol and drug treatment services provided in a residential setting	None - Direct contracts with all providers			<1%
Psychiatric Day Treatment Service for Children	Psychiatric day treatment service delivered in a facility-based setting.	MHO-provider direct billing to DMAP for non-MHO enrolled kids	Y		<1%
Children's Statewide Wraparound	Services and supports for children with complex behavioral health needs and their families.	MHO	Y		<1%
Personal Care 20 Client Employed Provider for People with Mental Illness	Intensive community or in-home supports to assist Medicaid eligible, disabled individuals with activities of community living.	Client employs provider			<1%
*** Residential alcohol and drug treatment providers are not required to enter in to contracts with CCOs until July 1, 2013, but may do so at an earlier date.					

**APPENDIX F**  
**Example List of Medicaid Services and Programs For Inclusion in**  
**CCO Global Budgets**

Medicaid Program/Services	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?		% of Non-LTC Medicaid Spend
<b>Seniors &amp; People with Disabilities</b>	<b>Descriptions</b>				
Payment of Medicare premiums for dual eligibles	Medicare premium payments for dually eligible paid by Medicaid	N/A	Y		4%
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Applicable deductibles, coinsurance, and copayment amounts for dually eligible enrollees	N/A			<1%
OHP Post Hospital Extended Care	Provides a stay of up to twenty days in a nursing facility to allow for discharge from a hospital to a nursing facility	FFS Only	Y		<1%
<b>Public Health</b>	<b>Descriptions</b>				
School-Based Health Center Services	Comprehensive primary care clinics that provide physical, mental and preventive health services to school-aged children in a school-based setting.	Local Public Health Authority (LPHA)			1%
Babies First!	A Medicaid funded nurse home visiting program for families with babies & young children up to 5, with significant health & social risks. Provides health assessments, aligns community resources, strengthens parenting skills, and improves infant health outcomes.	Local Health Departments			<1%
Maternity Case Management	An education and support program for pregnant women on Medicaid with social or health concerns during pregnancy to improve health outcomes.	Local Health Departments (DMAP provides reimbursement for MCM services to a broader community of prenatal care providers not under the public health program)			<1%

**Appendix G**  
**Principles, Domains and Example CCO Accountability Metrics**  
 OHPB Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics

Potential CCO Performance Measures

At a minimum, any selected performance measure selected should meet standard scientific criteria for reliability and face validity. Potential measures should also be evaluated against the principles below, with the goal of establishing a set of CCO performance measures that reasonably balances the various criteria. OHA should re-examine selected measures on a regular basis to ensure that they continue to meet criteria.

<b>Principle</b>	<b>Selection criteria</b>	<b>Change criteria</b>
Transformative potential	<ul style="list-style-type: none"> <li>○ Measure would help drive system change</li> </ul>	<ul style="list-style-type: none"> <li>○ Measure reinforces the status quo rather than prompting change</li> </ul>
Consumer engagement	<ul style="list-style-type: none"> <li>○ Measure successfully communicates to consumers what is expected of CCOs</li> </ul>	<ul style="list-style-type: none"> <li>○ Measure is not understandable or not meaningful to consumers</li> </ul>
Relevance	<ul style="list-style-type: none"> <li>○ Condition or practice being measured has a significant impact on issues of concern or focus*</li> <li>○ Measure aligns with evidence-based or promising practices</li> </ul>	<ul style="list-style-type: none"> <li>○ Lack of currency - measure no longer addresses issues of concern or focus*</li> </ul>
Consistency with existing state and national quality measures, with room for innovation when needed	<ul style="list-style-type: none"> <li>○ Measure is nationally validated (e.g. NQF endorsed)</li> <li>○ Measure is a required reporting element in other health care quality or purchasing initiative(s)</li> <li>○ National or other benchmarks exist for performance on this measure</li> </ul>	<ul style="list-style-type: none"> <li>○ Measure loses national endorsement</li> <li>○ Measure is unique to OHA when similar standard measures are available</li> </ul>
Attainability	<ul style="list-style-type: none"> <li>○ It is reasonable to expect improved performance on this measure (can move the meter)</li> </ul>	<ul style="list-style-type: none"> <li>○ CCO or entity performance is “topped out”</li> <li>○ Measure is too ambitious</li> </ul>
Accuracy	<ul style="list-style-type: none"> <li>○ Changes in CCO performance will be visible in the measure</li> <li>○ Measure usefully distinguishes between different levels of CCO performance</li> </ul>	<ul style="list-style-type: none"> <li>○ Measure is not sensitive enough to capture improved performance</li> <li>○ Measure is not sensitive enough to reflect variation between CCOs</li> </ul>

Feasibility of measurement	<ul style="list-style-type: none"> <li>○ Measure allows CCOs and OHA to capitalize on existing data flows (e.g. state All Payer All Claims reporting program or other established quality reporting systems)</li> <li>○ Data collection for measure will be supported by upcoming HIT and HIE developments</li> </ul>	<ul style="list-style-type: none"> <li>○ Burden of data collection and reporting outweighs the measure's value</li> </ul>
Reasonable accountability	<ul style="list-style-type: none"> <li>○ CCO has some degree of control over the health practice or outcome captured in the measure</li> </ul>	<ul style="list-style-type: none"> <li>○ Measure reflects an area of practice or a health outcome over which CCO has little influence</li> </ul>
Range/diversity of measures	<ul style="list-style-type: none"> <li>○ Collectively, the set of CCO performance measures covers the range of topics, health services, operations and outcomes, and populations of interest</li> </ul>	<ul style="list-style-type: none"> <li>○ There is a surplus of measures for a given service area or topic</li> <li>○ Measure is duplicative</li> <li>○ Measure is too specialized</li> </ul>

\* These issues include, but are not limited to: health status, health disparities, health care costs and cost-effectiveness, access, quality of care, delivery system functioning, prevention, patient experience/engagement, and social determinants of health.

### Domains of Measurement

OHA should assess CCO performance in two primary domains:

- Accountability for system performance in all service areas for which the CCO is responsible:
  - Adult mental health
  - Children's mental health
  - Addictions
  - Outpatient physical
  - Inpatient physical
  - Women's health
  - Dental
  - Prevention
  - End-of-life care
- Accountability for transformation:
  - Care coordination and integration
  - Patient experience and activation
  - Access
  - Equity
  - Efficiency and cost control
  - Community orientation

## Potential CCO Performance Measures

*\*Examples Only\**

- Rate of tobacco use among CCO enrollees
- Obesity rate among CCO enrollees
- Low birth weight
- Breastfeeding exclusivity at 6 months
- Well child visits
- Dental visits (% of members with any visit in past year)
- Wait time for dental visit
- Depression screening
- Alcohol screening (e.g. SBIRT)
- Initiation & engagement in drug, alcohol, and mental health treatment
- Penetration rate for mental health and chemical dependence treatment
- Cholesterol control for patients with CAD
- Cholesterol control for patients with diabetes
- Glucose control for diabetics
- Cancer screening (1 of: cervical, breast, or colorectal)
- Effective contraceptive use and unintended pregnancy
- Chlamydia screening
- Fall risk screening (older adults)
- Service engagement (% members who received no health services at all in x period)
- Member or patient experience with:
  - Getting needed care & getting care quickly
  - Shared decision making and participation in care planning
  - Care coordination
  - Chronic disease self-management support
  - Primary provider or provider team
  - Overall experience of care
- Primary care-sensitive hospital admissions (AHRQ PQIs)
- ED visits by primary diagnosis (e.g. mental health, substance abuse, dental, other)
- Hospital acquired infection rates
- Medication management (e.g. % discharges where medications were reconciled within 7 days)
- Follow-up after hospitalization (visit within 7 days of discharge for physical or mental health diagnosis)
- Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)
- End of life care preferences (e.g. % dual eligibles or age-specified members who have a POLST form on file)
- Health status improvement
- Functional status improvement

Accountability by Level

*Illustrative examples for discussion purposes only*

**Example Domain: Care Coordination**

	<b>CCO Criteria (Structure)</b>	<b>Process Metrics</b>	<b>Outcome Metrics</b>	<b>Triple Aim</b>
<b>Macro: OHA</b>	<p>Establish recognition process for PCPCHs</p> <p>Administer EHR incentive program Facilitate HIE (e.g. connect regional HIOs, Direct Project)</p>	<ul style="list-style-type: none"> <li># of PCPCHs recognized</li> <li>% of eligible providers and hospitals meeting Meaningful Use</li> </ul>	<ul style="list-style-type: none"> <li>% of OHA-covered lives with access to PCPCH</li> <li>OHA roll-up: ambulatory care-sensitive hospital admissions</li> <li>Statewide EHR adoption</li> <li>Statewide HIE participation</li> <li>OHA roll-up: Medication errors, duplicate testing</li> </ul>	Better care, lower costs
<b>Meta: CCO</b>	<p>Incorporate OHA-recognized PCPCHs into CCO network</p> <p>Support clinical information exchange among CCO providers (e.g. act as or participate in regional HIO; use Direct)</p>	<ul style="list-style-type: none"> <li>Member experience of care coordination (e.g. shared decision making composite)</li> <li>% members with individual care plan</li> <li>Medication management - % members with medications reconciled within 7 days of hospital discharge</li> </ul>	<ul style="list-style-type: none"> <li>Rate of ambulatory care-sensitive hospital admissions</li> <li>Member experience of care overall</li> <li>Medication errors</li> <li>Duplicate testing</li> </ul>	<p>Better health, lower costs</p> <p>Better care</p>
<b>Micro: Practice or Provider</b>	<p>Implement PCPCH standards, seek recognition</p> <p>Identify, track and proactively manage patient care electronically using up-to-date information</p>	<ul style="list-style-type: none"> <li>% members assigned to personal provider or team</li> <li>Screening for depression and follow-up plan</li> </ul>	<ul style="list-style-type: none"> <li>Benchmark for continuity of care</li> <li>% patients showing improvement on clinically valid depression tool</li> </ul>	<p>Better care</p> <p>Better care, lower costs</p>

■ Collected by OHA

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# **CCO Implementation Proposal**

## **Public Comment Summary**

**January 5, 2012**

For full text of each comment, please visit: [www.oregon.gov/OHA/OHPB/meetings](http://www.oregon.gov/OHA/OHPB/meetings)

PDF Book mark No.	Category	Organization or Person	Comment
2	<b>Metrics: Women's reproductive health</b>	Oregon Foundation for Reproductive Health	There is an important omission to the proposal: There are no core measures which address women's preventive reproductive health. This is a critical oversight, and one that needs remedying, specifically: <b>1)</b> Unintended pregnancies should be tracked by CCOs as a Core Measure and an indicator of whether women are receiving the reproductive health services they need. <b>2)</b> The percentage of women using contraception that meets their needs should be tracked by CCOs as a Core Measure, and routine assessment of women's contraceptive needs should be a standard in primary care. <b>3)</b> The percentage of pregnant women who began taking folic acid prior to pregnancy should be tracked by CCOs as a Core Measure, and a marker of delivery of preconception service availability and prevalence.
23	<b>Metrics: Chronic mental illness</b>	Oregon Residential Provider Assoc.	Mental health is NOT a monolithic area of health care. Residential mental health serves the chronically and persistently mentally ill. See email for specific list of outcome measures.
8	<b>Metrics: Smoking cessation</b>	Colleen Hermann-Franzen, American Lung Assoc., Oregon	<ul style="list-style-type: none"> <li>• Please keep "tobacco assessment and cessation" as one of the core metrics.</li> <li>• Please consider revising the categorization of "flu vaccination for pneumonia patients, aged 50 years or older" from a menu metric to a core metric.</li> <li>• Please consider updating the categorization of "rate of tobacco use among CCO members" from a developmental metric to a core metric.</li> </ul>
37	<b>Metrics: Care coordination</b>	Assoc. of Ore. Comm. Mental Health Programs	There should be performance measures that address integration of care coordination between physical, behavioral and oral health.

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10	<b>Metrics: Recovery Outcomes</b>	Stephen McCrea	Hospital readmission rates are indeed an important outcome measure, but we need to go beyond that to things like employment, community activity, social relationships, etc. Quality of life outcomes, in essence. We should be in the business of improving people's lives, not simply keeping them from costing us more money.
16	<b>Metrics: Equity</b>	Multnomah County	Data collection should include health disparity related indicators, including community comparisons within the same service area.
16	<b>Accountability</b>	Multnomah County	CCOs should provide yearly information on salaries of top wage earners; streamline administrative requirements across the system
19	<b>Accountability</b>	Matt Borg	No where in the CCO proposal does it mention accountability on the part of the PATIENT.
17	<b>Accountability</b>	Oregon Primary Care Assoc.	CCOs need to be held accountable to the public. The CCO Implementation Plan should clearly indicate those elements that <u>must</u> be a part of the CCOs structure. The plan should also include a much more specific timeframe. Transparency is a must. Comments also include changes to the DRAFT Matrix of CCO Criteria.
21	<b>Accountability</b>	Oregon Medical Assoc.	Patient engagement is so important to the success of the CCO that we would like to see the addition of member incentives to prioritize healthy lifestyles.
27	<b>Governance: Public representation</b>	Liz Baxter, Community Leadership Council	The <u>majority</u> of the governance body should reflect and represent those people being served, rather than those with a financial risk. Another suggestion: consider using a modern "For-public-benefit" model rather than simply the outdated for-profit vs. not-for-profit.
3	<b>Governance: Counties</b>	Jan Kaplan, Curry County Health and Human Services Director	I would recommend that thought be given to including Counties statutorily within the 51% of risk bearing entities on any CCO governance structure. This is based on the concept that counties will bear significant financial risk to public dollars (both local and state) depending upon policies, decisions and performance of CCO's.

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4	<b>Governance, Risk Adjusting</b>	Ted Amann, Central City Concern	<p><u>CCO governance:</u></p> <ul style="list-style-type: none"> <li>• The concept of "financial risk" needs to be broadly defined. I was disappointed to see that between the previous month's draft business plan and the more recent draft implementation plan the language that said this risk includes those with indirect risk was removed. I think you had it right the first time.</li> <li>• The governing board must reflect the community the CCO purports to serve.</li> </ul> <p><u>Risk Adjusting:</u></p> <ul style="list-style-type: none"> <li>• There must be a risk adjusting mechanism more robust than the current one that only includes age, sex, geography, and eligibility category.</li> </ul>
16	<b>Governance: Public representation</b>	Multnomah County	Transparency is crucial; additional clarification is needed on how consumers without financial risk will be included in the CCO governing board; community engagement should extend beyond individuals, to whole communities.
22	<b>Governance : Public representation</b>	Mid-Valley Health Care Advocates	OHPB should require significant public representation on the CCO governing boards, as well as representation from public health.
31	<b>Governance: Beneficiary representation</b>	Oregon Health Action Campaign	CCO beneficiaries and their advocates should be directly represented in CCO governance bodies.
32	<b>Governance: Counties</b>	Liane Richardson, Lane County	Public entities should be better represented in governance. Forming a public-private partnership is not simple. To have a public entity with voting rights sit on an otherwise private board of directors may take legislative action and possibly face constitutional hurdles.
37	<b>Governance: Counties</b>	Assoc. of Oregon Counties	Counties share a financial risk in terms of contributing general funds and in terms of providing safety net services at risk of being overburdened by faltering CCOs. Counties should therefore be included on governing boards.

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21	<b>Governance: Providers</b>	Oregon Medical Assoc.	As currently defined, the structure does not allow for an equitable decision-making process to be established. No stakeholder should have an advantage over another. Physician membership should be ensured as part of the government structure.
28	<b>Equity</b>	Jennifer Valentine	More detail on ensuring adequate tracking and elimination of health disparities is essential, as is a mechanism of enforcement. This includes the importance of qualified interpreters, cultural competency training, best practice methodologies training, etc.
33	<b>Equity</b>	American Heart Assoc.	CCOs should ensure that the board makeup reflects underserved communities.
34	<b>Equity</b>	Josiah Hill Clinic	CCOs should ensure that the board makeup reflects underserved communities, seniors, people with disabilities, and people using mental health services. Ensure equal patient access through staffing and training protocols, and best practice sharing. CCOs falling behind in these outcomes must create an equity improvement plan.
35	<b>Equity</b>	211 Info	CCOs should ensure that the board makeup reflects underserved communities. Services should be located geographically as close as possible to members' residences.
38	<b>Equity</b>	Ore. Assoc. of Hospitals and Health Systems	CCOs must be tasked with making progress in the reduction of health disparities, however eliminating them altogether will require a concerted, collaborative effort that engages virtually every sector of the community.
25	<b>Global budget: Actuarial soundness</b>	Providence Health & Services	"Lowest cost estimate" is not an actuarially sound method. In the early development stages, focus should be on bending the cost curve. CCOs should be rewarded for hitting established targets, rather than the lowest cost estimate approach that effectively requires CCOs to bid and bet on the cost of caring for their population. Also, budgets must include risk adjustment.
37	<b>Global Budget</b>	Assoc. of Oregon Counties	Important that Medicaid funded programs do not lose funding because of fewer resources in the global budgets resulting in a loss of local or federal match.

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38	<b>Global budget: Actuarial Soundness</b>	Ore. Assoc. of Hospitals and Health Systems	The Proposal recommends setting the global budget capitation rate using a method similar to the problematic "lowest cost estimate" approach. It has minimal relationship to the principles of actuarial soundness and CMS describes it as highly unusual. It is not a valid way to build health plans with adequate provider networks. Also, we advocate for CCO Global Budgets to be all-inclusive.
17	<b>Global budget: Account for social barriers</b>	Oregon Primary Care Assoc.	CCO measurement and payment should account for psychological and social barriers to health. Without such accounting, providers who serve this challenging and costly population will be unfairly penalized. Additionally, global budgeting process should be guided by clear principles to avoid negative consequences for access, coverage of funding.
4	<b>Fast track</b>	Ted Amann, Central City Concern	I am concerned that the "fast track" from MCO to CCO that Rep. Freeman and Sen. Bates advocated for will be used as a way for existing organizations to get around the transformative demands of the new system. Also, the process for evaluating CCO applications should be as transparent as possible.
27	<b>Fast track</b>	Liz Baxter, Community Leadership Council	Current Medicaid MCOs should not be fast tracked -- we cannot transform while simultaneously staying the same. They should go through a transition phase, but should have to meet all CCO requirements before certification.
38	<b>Fast track</b>	Ore. Assoc. of Hospitals and Health Systems	There should not be a head start for Medicaid MCOs to the disadvantage of other would-be CCOs. We are concerned that fast track merely creates the illusion of transformation.
18	<b>Choice</b>	BJ Merriman	It is important that patients can have flexibility in choosing a doctor, clinic, dentist, etc. If someone is unsatisfied with the doctor they get, could they switch?
36	<b>Choice</b>	State Independent Living Council	Consumers must have a choice in their PCPCH; CCOs cannot have the power to assign.

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22	<b>Best practices</b>	Dr. Hsichao Chow	To ensure uniform, high quality care, best practices of all fields must be practiced. Such best practices must be continuously updated according to medical advancements. OHA should develop a division of Best Practices of Health Care (BPHC).
7	<b>Incentives</b>	Lori Karaian, Health Management Systems	Given the federal and CMS mandate, and the potential financial impacts, HMS recommends Oregon not only maintain payment integrity initiatives under the new CCO model, but maximize their use through proper incentive structures. It is important to maintain fiscal integrity. See email for more details -- pg. 15
20	<b>Incentives</b>	Cynthia Ross	I am concerned that there will not be sufficient financial incentives for a provider to treat members of a CCO.
23	<b>Mental health</b>	Oregon Residential Provider Assoc.	Mental health is NOT a monolithic area of health care. Residential mental health serves the chronically and persistently mentally ill.
9	<b>Behavioral and Mental Health Services</b>	Kelli Pellegrini	<p>I have been somewhat alarmed at the lack of clarity on Behavioral Health/Mental Health Service delivery. Specifically, I am concerned that in the new delivery model providers of Behavioral Health services will be lumped into a single category (psychologists, social workers, licensed professional counselors, and marriage and family therapists), with no differentiation in levels of education, license or expertise, which will not serve the needs of Oregonians well at all. In an effort to conserve resources and reduce costs, I believe that it may be tempting for the Oregon Health Authority to forward the notion that masters-level providers are the "same as" doctoral level providers. This would be a mistake, both in terms of quality of care and ultimately financially: Patients can't and won't get better if they are receiving inadequate treatment, which over time increases costs.</p> <p>Any aspect of CCO development that potentially compromises patient care in order to save money runs diametrically contrary to the stated goals of the OHA.</p>

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11	Peer support	Helen Lara, Mid-Valley Behavioral Care Network	Advocating that the Board understand the importance of having an <u>array</u> of peer services for people with mental health and substance abuse issues and to include funding opportunities for them in the future.
14	Peer support	Fred Abbe	In support of funding services provided by peer services.
36	People with disabilities	State Independent Living Council	Strongly urge a consistent, well-defined mandated partnership between OHA and the Oregon Disabilities Commission in the further development, implementation and monitoring of this vital system change. While system change will have an impact on everyone, it is vital that for people with disabilities that services and infrastructure, including knowledge and access to expertise, are in place and operational from the very beginning. Also, good employment supports, a robust grievance and complaint system and Ombudsperson.
16	Continuity of care	Multnomah County	Continuity of care must be considered during the application process.
16	Continuity of care	Multnomah County	Continuity of care must be considered during the application process. PCPCHs must develop in the proper settings. Oral health should be sufficient to assure access to preventive oral health services.
15	Deadlines	Carolynn Kohout	Essential that hard deadlines are created for implementation, otherwise, nothing will ever get done.
30	Food and nutrition	David McIntyre	The importance of diet and nutrition as a preventive, upstream health focus is increasingly acknowledged. This should be integrated into CCO care and education for patients, as it has been shown to generate enormous cost savings.
22	Transparency	Mid-Valley Health Care Advocates	OHA should ensure that public hearings are held on each CCO application.

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37	<b>Comm. Needs assessment</b>	Coalition of Local Health Officials	Important to have a community needs assessment that creates a planning process that fosters consistent engagement and collaboration and allows you to learn about the community as it changes, develops, and becomes sicker or more healthy. The five major areas of measurement should include: 1) data sources 2) demographics 3) health issues and population groups with health issues 4) continuing causes of issues 5) existing community assets.
250	<b>Naturopathic Doctors</b>	<b>Over 250 emails</b>	<b>Over 250 emails were received relating to the importance of including non-discrimination language regarding the use, availability, proper reimbursement, etc. of Naturopathic Doctors, chiropractors, allopaths, and others that fall into the category of Complimentary and Alternative Medicine (CAM).</b>
26	<b>Dental</b>	Willamette Dental Group	On page 16, it says a CCO must have formed a contractual relationship with a DCO in its area by 7/1/14. To ensure continuity of care, it should say that a CCO must contract with all DCOs that serve members of the CCO in the area where they reside by 7/1/14. If not handled correctly, Oregon is at risk of losing a successful dental delivery system built over time by investment of Oregon taxpayer dollars.
29	<b>FQHCs</b>	Yakima Valley Farm Workers Clinic	Important to ensure that CCOs include FQHCs and other safety net providers in their networks. A CCO should not be permitted to unreasonably refuse to contract with a licensed health care provider.
33	<b>Tobacco and Obesity</b>	American Heart Assoc.	Preventive benefits for tobacco use and obesity must be included in all Medicaid benefit plans, including smoking cessation benefits and preventive benefits for cardiovascular diseases and stroke.
37	<b>Care coordination</b>	Assoc. of Ore. Comm. Mental Health Programs	The population referred to as those with extensive care coordination needs should include individuals across the age spectrum with mental illness, addictions and co-occurring disorders. Half the high costs 10/70 population suffers from mental illness.

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15	<b>Optical/glasses</b>	Carolynn Kohout	Important for patients to have good optical options for care.
5	<b>Advanced Directives</b>	Amy Veatch, Oregon Health Decisions	How can/should Advanced Directives fit into CCOs?
6	<b>Chronic Pain</b>	Michelle Underwood	For patients with chronic pain, it is essential that providers have the ability and knowledge to help maintain an appropriate (not too small or too large) dosage of medicine. Systematic evaluation techniques should be put in place, as should "pain contracts" between doctor and patient. See email for more details, pg. 13
1	<b>Hemophilia treatment</b>	Hemophilia Foundation of Oregon	Hemophilia affects 20,000 people in the US, and approximately 400 in the state of Oregon. Most individuals with hemophilia receive care at hemophilia treatment centers (HTCs). Studies have shown that mortality and hospitalization rates are 40% lower for people who use HTCs than in those who do not, despite the fact that more severely affected patients are more likely to be seen in HTCs. Bleeding disorder patients need specialized health care that is best provided by federally funded hemophilia treatment centers (HTCs). It is critically important that people with hemophilia and other bleeding disorders have in-network access to HTC care through CCOs and QHPs offered in the exchanges. We ask that patients in CCOs/QHPs are not required to have copayments or coinsurances that are so high that patients will avoid getting needed factor replacement therapy. Patients with bleeding disorders must have access to the site of care that is determined by the patient and his/her physician. Continuity of Care: Patients who may find they need to switch enrollment between CCOs and QHPs must have protections in place so they do not have to seek reauthorization of services or treatments.
12	<b>SAIF</b>	Dean McAllister	SAIF would be a natural health care insurance provider for Oregon.

PDF Book mark No.	Category	Organization or Person	Comment
13	Universal care	Claude and Lucy Thompson	Everyone, not just Medicaid, should be on the same health care system, that way everyone would have the same access.
25	General	Providence Health & Services	The plan must be: 1) flexible enough to create structures that work in individual communities, 2) efficient enough to make the changes that will have a lasting, positive impact, 3) capable of evolving as we discover the best structures to meet the Triple Aim.
24	General	South Coast Providers	We are concerned that the CCO Implementation Proposal leaves too much uncertainty, and often does not adequately elaborate on language already found in HB 3650. We understand the risk of being overly prescriptive, but a better balance must be found.