

Oregon Health Policy Board

AGENDA

April 10, 2012

Webinar

1 pm to 2:30 pm

[Register for the webinar](#)

Public LISTEN-ONLY call in line: Dial 877-581-9247, participant code 604851

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll call Consent agenda: 3/13/12 minutes	Chair	X
2	1:05	Director's Report <ul style="list-style-type: none">CMS update	Bruce Goldberg	
3	1:10	CCO Implementation <ul style="list-style-type: none">Letters of Intent: Who applied in what areas of the stateNext steps in procurementOHA internal implementationCommunication planPermanent rules process	Judy Mohr-Peterson Patty Wentz	
4	2:10	Update on Essential Health Benefit Workgroup	Jeanene Smith	
5	2:15	OHPB Strategy Session	Tina Edlund	
7	2:30	Adjourn	Chair	

Next Meeting:

OHPB Strategy Session

May 24, 2012

8 a.m. to 5 p.m.

Location TBD

Oregon Health Policy Board
DRAFT Minutes
March 13, 2012
8:30am to 12pm
Market Square Building
1515 SW 5th Ave, 9th Floor
Portland, OR 97201

Item
<p>Welcome and Call To Order Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present, except Vice-Chair Lillian Shirley.</p> <p>Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p> <p>Consent Agenda: The minutes from the February 14, 2012 meeting were unanimously approved.</p>
<p>Director's Report – Bruce Goldberg Bruce Goldberg gave a legislative update regarding SB 1580 and HB 4164. He also spoke about next steps in the Transformation effort. Goldberg said the CCO timeline is driven by the application period and allowing enough time for review, both by the state and CMS.</p> <p>Goldberg also gave an update about the effects of the state's budget shortfall on the OHA. He said some of the areas affected are the Oregon State Hospital, tobacco and gambling prevention, and administration. Goldberg said the number of OHA staff is down by 10% from six months ago and that reduction will likely double in the future.</p> <p><i>The Director's Report can be found here, starting on page 7.</i></p>
<p>All Payer All Claims Update – Gretchen Morley Gretchen Morley gave an update on the All Payer All Claims database. Morley said approximately 90 million claims have been submitted by 37 payers. She said Milliman, who was awarded the contract in 2010, is currently loading data into the dashboard, creating data "cubes," testing data and ensuring access levels are appropriate and training staff on the MedInsight analytical tool. Morley also said next steps will include completing the initial validation work, loading data into the dashboard, continuing staff training with MedInsight, and finalizing administrative rules.</p> <p><i>The All Payer All Claims presentation can be found here.</i></p>
<p>CMS Waiver Summary – Judy Mohr Peterson Judy Mohr Peterson spoke about the CMS waiver and gave an overview of the Oregon Health Plan. She said its since implementation in 1994, the Oregon Health Plan has saved the state and federal government \$16 billion. Mohr Peterson said most of what is to be accomplished through Transformation can be done under Oregon's original 1115 federal waiver but amendments were submitted on March 1 asking for some additional waiver authority. She said the most of the federal flexibilities needed to change OHP involve payment systems.</p> <p><i>The Transforming the Oregon Health Plan presentation can be found here.</i></p>
<p>Next Steps and Implementation Update – Judy Mohr Peterson Judy Mohr Peterson spoke about next steps in the process, including temporary and permanent rules to implement SB 1580, a request for application and the Medicare-Medicaid integration proposal.</p> <p>Mohr Peterson also highlighted key dates in both the CCO Implementation and Medicare-Medicaid Integration timelines and presented cco.health.oregon.gov.</p> <p><i>The Transforming the Oregon Health Plan presentation can be found here.</i></p>
<p>Essential Health Benefit Development – Jeanene Smith Jeanene Smith presented a charter for the Essential Health Benefits Workgroup. Smith said the</p>

Governor's Office wants the workgroup to develop a public process and discussion around how the state will choose the Essential Health Benefits benchmark plan. She said the workgroup will also review potential legislative language, if needed, for implementation.

Nita Werner moved to approve the Essential Health Benefit Charter; Joe Robertson seconded the motion. The motion passed 7 Ayes, 0 Nays, 1 Excused (Lillian Shirley)

The Essential Health Benefits Charter can be found [here](#), starting on page 39.

Board Schedule/Retreat – Chair Eric Parsons

Chair Eric Parsons led a discussion about the Board's upcoming schedule and an all-day retreat to develop the work plan in May.

Bruce Goldberg gave an update on the Early Learning Council and its future relationship with the Board. He said a formal workgroup will be created to dovetail transformative efforts.

Public Testimony – Chair Eric Parsons

The Board heard testimony from three people:

Charles Maclean, Philanthropy Now, spoke about patient responsibility and engagement. He said engaging a patient advocate provides additional support and greatly improves health outcomes.

Anne Morrill, Oregon Foundation of Reproductive Health, spoke about the Request for Applications for CCOs. She spoke about reproductive health metrics, including preventing unintended pregnancies and providing contraceptive care.

Carolyn Kahut, home care worker, had questions regarding rules and CCO contracts.

Adjourn

Next meeting:

April 10, 2012

1 p.m. to 2:30 p.m.

Webinar

Health Information Technology Oversight Council

OHA Director's Report, April 3, 2012

Below is a summary of Health Information Technology Council (HITOC) and related workgroups, panels, and stakeholder meetings from Jan.7 – April 3, 2012. Full meeting summaries are available on the HITOC website at: <http://www.oregon.gov/OHA/OHPR/HITOC/index.shtml>.

January 25, 2012, Consent Implementation Subcommittee: Members received a presentation on the four most prominent models of electronic health information exchange (HIE) currently in use, and discussed and further developed recommendations for HITOC on how to implement the opt-out consent policy for HIE. The Subcommittee generally supported the following policy, but questions remain:

Opt-out opportunity: If protected health information is disclosed into a query-able database managed/owned by a third party, which aggregates data on patients from multiple sources and makes that aggregate data available to multiple entities, then patients should be given the opportunity to opt-out of having their data disclosed into the database. The opportunity to opt-out would not apply to the disclosure of protected health information for the purposes of payment, public health reporting, health care operations, or for any disclosure required by law.

A remaining question is what the implications for patient consent would be if a query-able database were used for multiple purposes, including treatment and one or more other purposes for which the opt out opportunity would not apply (payment, healthcare operations, etc.). There were questions about whether, for example, CCOs might need to combine patient data in a query-able database that could be used for the purposes of treatment, payment, and quality improvement/health care operations.

January 31, 2012, Consumer Advisory Panel: The March 7 HITOC Retreat was announced and Panel members requested having representation and a consumer-focused agenda item at the Retreat. Direct Secure Messaging services were presented by staff and discussed. It was noted that Direct will primarily be used for provider-to-provider communications in phase 1, but that several personal health record (PHR) products are enabled to receive Direct messages, which allow doctors to send patients their health information via Direct to their patient's PHR. Other issues related to consumer engagement around HIE were discussed, including the need to develop the value proposition for patients and consumers. The Panel also discussed the recommendations from the Consent Implementation Subcommittee and raised several questions about data access, storage, and correction in the statewide Direct Secure Messaging services; staff is following up with the necessary experts to answer these legal and technical questions. Finally, Panel members were introduced to several new HIT tools and resources developed as part of the ONC Consumer e-Health Program.

February 2, HITOC: Council members received an update about the work of the Consent Implementation Subcommittee and discussed the complexity of the issues and fluidity of the environment. In addition, council members received updates about the Medicaid EHR Incentive Program; the Statewide HIE Direct Services launch, scheduled for March 2012; the Medicaid Information Technology Architecture (MITA) State Self-Assessment; and e-Prescribing efforts in Oregon. Continuing their discussion of Oregon's Strategic Plan for HIT, council members considered underlying principles that can be advanced through HIT, including the triple aim, the HITECH Act's goals, and health care equity. Council members also discussed organizing the plan around known advantages to HIT that will be most applicable for Oregon.

March 7, HITOC: During an all-day retreat, council members received updates about CareAccord, Oregon's Health Information Exchange (HIE); the Consent Implementation Subcommittee's January 31 meeting; new guidance from the Office of the National Coordinator for Health Information Technology (ONC); and activities of O-HITEC, OHSU and the Oregon Health Network (OHN). Dr. Susan Woods spoke with the council about patient-centered approaches to health IT. The council, in collaboration with stakeholders, discussed Oregon's Strategic Plan for Health IT, focusing on telehealth, HIE and electronic health records (EHRs) as initial areas for development and examining the current state, ideal state, barriers and potential strategies for each area. During a working lunch, Steve Gordon, the chair of HITOC, presented the HITOC Public Participation Award to Dr. Mike Saslow, and Tina Edlund provided an update and answered questions about SB 1580 (2012) and coordinated care organizations.

April 3, 2012, Consent Implementation Subcommittee:

The Consent Implementation Subcommittee met on April 3, 2012, to discuss their recommendation to HITOC for implementing the opt-out patient consent policy for health information exchange in Oregon. HITOC had previously affirmed that an opt-out policy was directionally correct and appointed the Subcommittee the task of developing the operational details to effectively implement such a policy through administrative rule. At the April 3 meeting, the Subcommittee proposed the following set of recommendations:

1. For point-to-point health information exchange, no additional patient consent should be required beyond what is already required by existing state and federal law.
2. The Subcommittee recommended not moving forward at this time in implementing an opt-out consent system for other types of HIE, including centralized query-response systems.
3. The Subcommittee recommended scheduling one additional meeting.

CCO Letters of Intent to Apply

The following entities have filed Letters of Intent expressing interest in applying to become a Coordinated Care Organization (CCO). The CCO Letters of Intent are summarized in the matrix below. Submitting a Letter of Intent does not obligate an entity to become a CCO and the information is non-binding. Letters may be amended or rescinded by the submitting entity.

CCO Name	Service Area	Affiliated Organizations	Start Date
Columbia Gorge Health Alliance	(1) Hood River; (2) Wasco; (3) Gilliam and (4) Sherman.	To be determined. Anticipated: Advantage Dental Services, LLC; Greater Oregon Behavioral Health ("GOBHI"); and PacificSource will each be part of CGHA's governance and delivery system.	8/1/12
CareOregon Columbia-Pacific Coordinated Care Organization	All of Columbia, Clatsop, and Tillamook Counties, and the 97449 zip code in Douglas County.	Not yet determined	10/1/12
CareOregon Jackson County Coordinated Care Organization	All of Jackson County, Oregon	Not yet determined	10/1/12
CareOregon Marion-Polk Coordinated Care Organization	All of Marion and Polk Counties, Oregon	Not yet determined	10/1/12
CareOregon Tri-County Coordinated Care Organization	All of Clackamas, Multnomah and Washington Counties, Oregon.	Not yet determined	10/1/12

Oregon Health Policy Board Meeting – 4/10/12

Submitted Letters of Intent to Apply

CCO Name	Service Area	Affiliated Organizations	Start Date
Tri-County Medicaid Collaborative	All of Clackamas, Multnomah and Washington Counties, Oregon.	Adventist Health; CareOregon; Clackamas County; FamilyCare; Kaiser Foundation Health Plan of the Northwest; Legacy Health; Multnomah County; the Metro Area Community Health Centers; Oregon Health & Science University; the Oregon Medical Association; the Oregon Nurses Association; Providence Health and Services; Tuality Healthcare; and Washington County.	8/1/12
Jackson County Coordinated Care Organization	Jackson County, Oregon	CareOregon, Inc.; ODS Community Health, Inc.; Asante Health System; and Providence Medford Medical Center	10/1/12
PrimaryHealth of Josephine County	All of Josephine County and contiguous Jackson and Douglas Counties: 97497, 97523, 97526, 97527, 97528, 97531, 97532, 97533, 97534, 97538, 97543, 97544, 97410, 97442, 97497, 97525, 97527, 97530, and 97537	CareOregon, Inc. and Grants Pass Management Services Inc. d.b.a. Oregon Health Management Services (OHMS)	8/1/12
Umatilla-Morrow CCO	all of Umatilla and Morrow Counties	CareOregon, Inc.	10/1/12
Caring Hand to Mouth	Eastern Lane County, including Cottage Grove 97424 population 16,668, Creswell 97426 population 7,460, Dexter 97431 population 2684, Fall Creek, 97438 population 1553, Lowell 97452 population 862, Oakridge 97463 population 3,760, Pleasant Hill 97455 population 3,039, Westfir 97492 population 640	Statewide Dental Services, P.C.; Statewide Contracting Services LLC; Cottage Grove Hospital; RiverBend and Campus Hospital where some of our providers are currently on staff.	8/1/12
Cascade Health Alliance, LLC	97601 and 97603	Cascade Comprehensive Care	8/1/12

Oregon Health Policy Board Meeting – 4/10/12

Submitted Letters of Intent to Apply

CCO Name	Service Area	Affiliated Organizations	Start Date
Community Health Alliance	Douglas County, including zip codes 97410, 97417, 97428, 97429,97432,97435,97436,97442,97443,97447,97455,97457, 97462,97469,97470,97471,97473, 97479,97481,97484,97485,97486,97494,97495, 97496, 97499, and 97731, and excluding those zip codes in the coastal Douglas County area, as members in that geographic area have traditionally been part of the medical community in Coos Bay, which excludes 97441, 97442, 97457, 97467, and 97473	<ol style="list-style-type: none"> 1. Umpqua Community Health Center ("UCHC"), a federally qualified health center 2. Mercy Medical Center, our community hospital, 3. ADAPT, an alcohol and drug treatment provider, 4. ATRIO, a Medicare Advantage Plan, 5. Advantage Dental, a dental care organization, 6. Greater Oregon Behavioral Health ("GOBHI"), a mental health managed care organization, 7. Douglas County Health and Social Services Department, 8. DCIPA, the sole member of DCIPA, LLC, a fully-capitated health plan, 9. Douglas County Board of Commissioners, represented by commissioner Susan Morgan 	8/1/12
Community Impact, Inc.- OREGON	97213	Community Impact; Siloam International, Inc.; Declare Therapy, Inc.	9/1/12
Coordinated Care of Oregon	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Lake, Lane, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill	None at this time	11/1/12

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Submitted Letters of Intent to Apply

CCO Name	Service Area	Affiliated Organizations	Start Date
Correctional Health Partners	CHP's services for hospitalized inmates would focus on those areas where ODOC facilities are located and where hospital inpatient services typically occur including Multnomah, Marion, Washington, Clackamas, Coos, Umatilla, Malheur, Baker, and Crook Counties.	ODOC and OHA	11/1/12
DCIPA LLC	Douglas County, including zip codes 97410, 97417, 97428, 97429, 97432, 97435, 97436, 97442, 97443, 97447, 97455, 97457, 97462, 97469, 97470, 97471, 97473, 97479, 97481, 97484, 97485, 97486, 97494, 97495, 97496, 97499, and 97731, and excluding those zip codes in the coastal Douglas County area, as members in that geographic area have traditionally been part of the medical community in Coos Bay, which excludes 97441, 97442, 97457, 97467, and 97473.	DCIPA LLC is contracted with DMAP to provide healthcare to Medicaid insured in Douglas County. DCIPA LLC is an integrated delivery network and includes a panel of physicians, ATRIO Health Plans, and Mercy Medical Center - an acute care hospital, an electronic health record and information system, a technology support service, a physician billing service, medical and case management services, and claims management including: 1. Physician and mid-level providers; 2. Mercy Medical Center, an acute care hospital; 3. ATRIO Health Plans; 4. Medical Management service; 5. UmpquaOneChart electronic health record system; 6. Professional Coding and Billing Service; 7. Physician e-Health Services; 8. Claims Management Services	8/1/12
FamilyCare, Inc.	All of Clatsop, Columbia and Tillamook counties, including contiguous zip codes in Yamhill county.	FamilyCare Health Plans	8/1/12
FamilyCare, Inc.	All of Gilliam, Hood River, Sherman and Wasco counties	FamilyCare Health Plans	10/1/12
FamilyCare, Inc.	All of Morrow and Umatilla counties	FamilyCare Health Plans	8/1/12

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Submitted Letters of Intent to Apply

CCO Name	Service Area	Affiliated Organizations	Start Date
FamilyCare, Inc.	All of Clackamas, Multnomah and Washington counties, including contiguous zip codes in Marian county	FamilyCare Health Plans	8/1/12
Good Shepherd Health Care System	Umatilla and Morrow counties	Unknown at this time.	11/1/12
Eastern Oregon CCO Collaborative	Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler counties	Hospitals and clinics within service area counties	11/1/12
Grants Pass Surgery Center	Josephine County	Asante and physician owners	11/1/12
Greater Oregon Better Health Initiative (GOBHI)	Baker, Clatsop, Columbia, Gilliam, Grant, Harney, Hood River, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler counties. Also residents in the following zip codes in the western part of Douglas County which will not be served by the Community Health Alliance: 97424, 97441, 97449, 97467, 97473, 97493, 97331, 97459. And any other rural county that expresses interest.	Potential affiliates: Oregon Dental Service; CareOregon; ATRIO Health Plans; PacificSource Health Plans; FamilyCare; Health Plans; Cascade Comprehensive Care, Inc.; Advantage Dental.	8/1/12
Homestead Youth and Family Services, Inc.	Umatilla County	Potential affiliate: Osoa Therapy	11/1/12

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Submitted Letters of Intent to Apply

CCO Name	Service Area	Affiliated Organizations	Start Date
Hood River County Cares	Hood River County	Pacific Source; GOHBI; local mental health providers; local hospital; local medical care providers; Hood River County Health Dept.; local federally qualified health center; dental providers	11/1/12
InterCommunity Health Network Coordinated Care Organization	Benton, Lincoln, and Linn counties	Samaritan Health Plans; Samaritan Health Services; InterCommunity Health Plans; Benton County; Lincoln county; Linn County; Accountable Behavioral Health Alliance; Mid Valley Behavioral Care Network; Oregon Cascades West Council of Governments; Capitol Dental Care	8/1/12
Kaiser Foundation Health Plan of the Northwest	Portions of Multnomah, Clackamas, Marion, and Polk counties, including the following zip codes: Multnomah: all except 97014, 97056, 97123, 97223, 97225, 97229. Clackamas: all except 97028, 97032, 97049, 97062, 97132, 97140, 97269. Marion: all except 97342, 97358, 97373, 97346, 97350, 97360. Polk: all except 97101, 97370, 97321, 97378. Intends to serve portions of Washington county effective as soon as practicable once its Westside Medical Center is operational	Not at this time	8/1/12

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CCO Name	Service Area	Affiliated Organizations	Start Date
Mid Rogue Independent Physician Association, Inc	Jackson: 97501, 97502, 97503, 97504, 97520, 97522, 97524, 97525, 97530, 97535, 97536, 97537, 97539, 97540, 97541. Josephine: 97544, 97543, 97538, 97534, 97533, 97532, 97531, 97527, 97526, 97523, 97497, 97528. Curry: 97406, 97415, 97444, 97464, 97465, 97476, 97491. Douglas: 97410, 97442.	Mid Rogue IPA Holding Company, Inc.; Mid Rogue Health Plan, Inc.; Mid Rogue Management Services Organization, LLC; Mid Rogue eHealth Services, LLC	8/1/12
The Northwest Portland Area Indian Health Board (NPAIHB)	The service area of Nine Federally-recognized Tribes in the State of Oregon. Specifically each Tribe's Contract Health Service Delivery Area (CHSDA) listed in the Federal Register. (See Federal Register / Vol. 72, No. 119 / Thursday, June 21, 2007).	Burns Paiute Tribe; Coos, Siuslaw and Lower Umpqua Tribes; coquille Tribe; Cow Creek Band of Umpqua; Grand Ronde Tribes, Klamath Tribes; Siletz Tribes; Umatilla Tribes; Warm Springs Tribes.	11/1/12
Clatsop and Columbia CCO	Clatsop County	ODS Community Health, ODS Health Plan	8/1/12
Eastern Oregon CCO	Counties: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler	Greater Oregon Behavioral Health, Inc.; ODS Community Health. Inc.; Tribal governments; federally-qualified health centers; rural health centers; and community advocates and organizations	8/1/12
Jackson County CCO	Jackson County	ODS Community Health; ODS Health Plan	8/1/12
Tri-Counties CCO	Clackamas, Multnomah, Washington, Columbia counties	Not known at this time, other than ODS Community Health, ODS Health Plan	8/1/12

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CCO Name	Service Area	Affiliated Organizations	Start Date
Willamette Community Care Organization (WCCO)	Marion, Polk, Yamhill	Not known at this time, other than ODS Community Health, ODS Health Plan	8/1/12
Oregon Sleep Center, LLC	Eastern Oregon, Hermiston, 97838 and surrounding counties.	None.	11/1/12
PacificSource Community Health Plans, Inc.	Desired Service Area by County: Deschutes, Crook, Jefferson, Harney, Grant, Lake (excluding zip codes 97620, 97630, 97635, 97636, 97367), and the following zip codes in Klamath County (97731, 97733, 97737, 97739)	Central Oregon Health Council; Deschutes County; Jefferson County; Crook County; St. Charles Health System; Central Oregon IPA; Mosaic Medical; and Advantage Dental. Other organizations may be added after additional discussion.	8/1/12
PacificSource Community Health Plans, Inc.	Desired Service Area by County: Hood River County, Sherman County, Wasco County, Gilliam County	La Clinica del Carino; Hood River County; Sherman County; Wasco County; Central Oregon IPA; Providence Hood River Memorial Hospital; Mid Columbia Medical Center; Mid Columbia Center for Living	8/1/12
Providence Health Assurance	Clackamas County, Multnomah County, Washington County, excluding 97106, 97109, 97113, 97116, 97117, 97119, 97123, 97124, 97125, 97133, 97144. Yamill County, only 97111, 97114, 97115, 97127, 97132.	To be determined.	10/1/12

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CCO Name	Service Area	Affiliated Organizations	Start Date
Western Oregon Advanced Health	The entire range of Coos County, Oregon. The entire range of Curry County, Oregon.	Adapt; Advantage Dental; Bandon Community Center (Rural Health Clinic); Bay Area Hospital (DRG Hospital); Bay Clinic; Coos County Mental Health; Coos County Public Health; Coquille Valley Hospital District (Type B CAH); Curry General Hospital (Type A CAH); Curry Health District; Curry Health Network; North Bend Medical Centers; Oregon DHS Senior and Disability Services; PacificSource; Powers Health District; South Coast Hospice; South Coast Orthopedic Associates; Southern Coos Hospital & Health Center (Type B CAH);, Southwest Oregon Independent Practice Association; Waterfall Community Health Center (FQHC).	8/1/12
Western Oregon Advanced Health	Western Douglas County: Winchester Bay - 97467; Reedsport-97467; Scottsburg-97473; Gardiner-97441 Western Lane County: Florence-97439, Mapleton-97453; Swisshome-97480; Deadwood-97430; Greenleaf-97445.	Adapt; Advantage Dental; Douglas County Mental Health; Douglas County Public Health; Dunes Family Health Care (Rural Health Clinic); Lane County Mental Health; Lane County Public Health; Lower Umpqua Hospital (Type B CAH); PacificSource; Peace Harbor Hospital (Type B CAH); Peace Harbor Rural Health Clinic; Reedsport Medical Clinic.	10/1/12
Trillium Community Health Plan (Trillium)	Lane County, Oregon	Lane County; LaneCare; Senior & Disabled Services; PacificSource; McKenzieWillamette Medical Center; Lane County Community Behavioral Health Consortium; PeaceHealth; and Lipa representing the physician delivery system.	8/1/12
Tuality Health Alliance	Washington County zip codes: 97006, 97007, 97064, 97106, 97109, 97113, 97116, 97117, 97119, 97123, 97124, 97125, 97133, 97144.	Tuality Health Alliance; Washington County Department of Health and Human Services; Virginia Garcia Memorial Health Clinic; and Pacific University Health Professions Campus; many others.	9/1/12

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CCO Name	Service Area	Affiliated Organizations	Start Date
UnitedHealthcare	Counties: Baker, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Gilliam, Grant, Harney, Hood River, Jefferson, Klamath, Lake, Lane, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler and Yamhill.	Unknown at this time.	9/1/12
Willamette Valley Community Health, LLC	Marion County (FIPS Code 047) and Polk County (FIPS Code 053) including zip codes 97071, 97362, 97002, 97032, 97375, 97346, 97350, 97352, 97358, 97360, 97362, 97375, 97383, 97101, 97347, 97361, 97378, 97396 that have addresses in contiguous Counties.	ATRIO Health Plans, Inc.; Capitol Dental Care, Inc.; Marion County Mid-Valley Behavioral Care Network; Mid-Valley IPA, Inc.; dba WVP Health Authority; Northwest Human Services; Polk County; Salem Clinic, P.C.; Salem Health/Salem Hospital; Santiam Memorial Hospital; Silverton Health West Valley Hospital; Yakima Valley Farm Workers Clinic	8/1/12
Warm Springs Health and Wellness Center, DHHS, Indian Health Service, Warm Springs Service Unit	97761	Confederated Tribes of Warm Springs	11/1/12

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CCO Name	Service Area	Affiliated Organizations	Start Date
Yamhill County Care Coordination	YCCO services will include all cities and zip codes within Yamhill County, and include the surrounding communities where clients typically seek services within Yamhill County. These include the following: 97101, 97111, 97114, 97115, 97119, 97127, 97123, 97128, 97132, 97137, 97140, 97148, 97304, 97347, 97371, 97378, 97338, 97071, 97002, 97026, 97396	Any existing Fully Capitated Health Plan (FCHP), Mental Health Organization (MHO) and Dental Care Organization (DCO) with members in the YCCO service areas will be considered as collaborative partners and possibly affiliate organizations. Additionally, YCCO anticipates working closely with the State's Division of Medical Assistance Programs (DMAP). Advantage Dental; Capitol Dental; CareOregon; Catholic Community Services; Chelhaem Medical Clinic; Chehalem Youth and Family Services; George Fox University; Lutheran Community Services NorthWest; McMinnville Physicians Organization; Mid-Valley Behavioral Care Network; NorthWest Senior and Disability Services; Physicians Medical Center; Providence Health Plan; Providence Newberg Medical Center and Medical Staff; Virginia Garcia Memorial Health Center; Willamette Valley Medical Center; Willamette Valley Provider Health Authority & Marion Polk Community Health Plan; Yamhill County Dental Society; Yamhill County Health and Human Services; Yamhill County Elected Officials & Citizens	11/1/12

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Timeline

Coordinated Care Organizations

(Current as of 3/20/12)

Public comment period. Documents will be posted at www.health.oregon.gov

Draft CCO Request for Applications (RFAs)	March 5 – 13, 2012
CCO model contract	March 5 – 13, 2012
Draft temporary rules	March 5 – 13, 2012
Temporary rules filed	March 16, 2012
Appoint Rules Advisory Committee for permanent rules development	March, 2012
Request for Applications for CCOs posted	March 19, 2012
Informational CCO applicant conferences	March 2012
<u>Deadline:</u> Non-binding Letter of Intent of CCO Application due to OHA	April 2, 2012
<u>Deadline:</u> Technical Application from CCO applicants due to OHA*	April 30, 2012
<u>Deadline:</u> Financial Application from CCO applicants due to OHA*	May 14, 2012
New Coordinated Care Organizations certified (first wave)	May 28, 2012
Medicaid Contract(s) signed by new CCOs	by June 29, 2012
Medicaid Contract to CMS for approval	by July 3, 2012
Medicaid Contract Effective for new CCOs	Aug. 1, 2012

*For first wave of applications

Note: There is a concurrent timeline of application deadlines for the Medicare-Medicaid Integration benefit package. Available at health.oregon.gov

Note: April 2, 2012 is the deadline for applicant non-binding Letter of Intent for first four waves of applicants. Any organizations or groups considering applying in 2013, are also encouraged to submit a non-binding Letter of Intent by April 2.

CCO Rolling Application Timelines

(Current as of 3/2/12)

	1st Application Wave Timelines	2nd Application Wave Timelines	3rd Application Wave Timelines	4th Application Wave Timelines
CCO Letter of Intent Due to OHA*	April 2, 2012	April 2, 2012	April 2, 2012	April 2, 2012
CCO Technical Application Due	April 30, 2012	June 4, 2012	July 2, 2012	Aug. 1, 2012
CCO Financial Application Due	May 14, 2012	June 11, 2012	July 9, 2012	Aug. 8, 2012
Award of Certification	May 28, 2012	July 2, 2012	Aug. 6, 2012	Sept. 5, 2012
CCO-Medicaid Contract Signed	June 29, 2012	July 30, 2012	Aug. 29, 2012	Sept. 28, 2012
CCO-Medicaid Contract to CMS	July 3, 2012	Aug. 1, 2012	Aug. 31, 2012	Oct. 1, 2012
CCO-Medicaid Contract Effective	Aug. 1, 2012	Sept. 1, 2012	Oct. 1, 2012	Nov. 1, 2012

* April 2, 2012 is the deadline for applicant non-binding Letter of Intent for first four waves of applicants. Any organizations or groups considering applying in 2013, are also encouraged to submit a non-binding Letter of Intent April 2.



Memorandum

To: Oregon Health Authority Cabinet Members, Health System Transformation (CCO Implementation) Executive Steering Team

From: Bruce Goldberg, M.D., OHA Director

Date: April 2, 2012

Subject: Health System Transformation & CCOs - How OHA will get it done

The Oregon Health Authority is at an important milestone. For more than a year we focused on the policies that led to the creation of the Coordinated Care Organizations (CCOs) that will serve members in the Oregon Health Plan. It has been an extraordinary effort by extraordinary people within and outside of the agency.

Now the policy proposal is a reality and by August 1, 2012 the first Coordinated Care Organizations should be open for business. Added to this, in 2014 there will be an estimated 200,000 Oregonians newly eligible for OHP through federal health reform.

That means a set of new challenges for us here at the agency.

It also means that implementation of Coordinated Care Organizations and transforming the Oregon Health Plan for better health, better care and lower costs will be our top priority for the foreseeable future.

In a time of limited resources to cover a body of work this critical to the state, we will have to be more creative and flexible than ever to get the work done.

With this memo I want to lay out the structure that has been set up to support the work ahead of us. This structure will help all of us understand who is accountable for which bodies of work and also provides a means for people to work together in new and, I predict, exciting ways to meet the challenge before us.

Here is the vision this structure is built upon:

Focus on health and health equity. Health isn't just about medicine any more. One of the most fundamental changes that Coordinated Care Organizations bring is that they will be accountable for the health of a community. The same is true for us, which means that as an agency we must begin to address the drivers of health and incorporate them in everything we

do. Addressing health disparities in the Oregon Health Plan is explicit in the laws that created CCOs. We will be working to ensure as an agency we put that focus front and center.

Coordination. As you will see when you look at how we've divided the work before us—into workstreams—they are not separated by divisions. The workstreams are designed to provide a model of the kind of coordination we need within OHA to provide support to new CCOs. The workstreams are also designed to eliminate redundancies, cut through red tape, and streamline operations.

Innovation. For CCOs to be successful, OHA must be an agency that stimulates and promotes innovation among our community partners and providers. They will be counting on us to help them figure out how they can make the new delivery system work. This means that as an agency we can and should move beyond thinking of ourselves as just regulators. We are all now innovators.

Flexibility. All of us at the Oregon Health Authority will be stretched in new ways to accomplish the tasks before us. We will be driven by rapidly approaching deadlines that require fast turnaround times with little room for error. To succeed we will need to reprioritize our work so that the tasks relating to transformation are completed accurately and on deadline. The workstream structure will be nimble and adapt as we move through the milestones to create Coordinated Care Organizations.

As we focus, coordinate, innovate and remain flexible – we are going to be called upon to work together in new and different ways. I know we are up to this challenge. There is not a state in the country with a health leadership team with more expertise, dedication and passion.

At the same time, while a singular mission can bring focus to an organization as large as ours, it also means that other work is delayed. While large goals can bring out the best in staff and allow them to work at the top of their game, it can also mean a temporary shake up of resources that can be confusing or stressful.

Attached to this memo you will find documents that lay out the workstreams and how they will function. If there is anything at all that isn't clear, please do not hesitate to contact Judy Mohr Peterson, the executive sponsor of this implementation project or any member of the Executive Steering Team. As those of you know who participated in the all-staff webinar presentation recently, this isn't the first communication about CCO Implementation, and it won't be the last.

Many thanks.

Health System Transformation / Coordinated Care Organizations Implementation

All work will flow through workstreams led by members of OHA Cabinet

To lead and support these workstreams, OHA Cabinet Members are stepping outside the traditional division structure.

Each OHA executive leading a workstream will be accountable for the tasks being completed no matter which parts of the agency will perform the work. This reflects the coordination necessary among health care providers for successful CCOs. It will require all OHA staff supporting workstreams to be both flexible and innovative. Each workstream lead must demonstrate a high degree of collaboration and teamwork, working across organizational boundaries and ensuring clear and consistent communication at all times.

The assigned leads for the teams within each workstream must also operate with this high degree of collaboration across organizational lines. They will serve as leaders within the Health Authority broadly speaking rather than narrowly for existing divisional lines. If there appears to be unclear or conflicting direction for any aspect of the work, the issue should be taken to the appropriate team leads for quick resolution.

Managing and prioritizing CCO Implementation

Many staff will help on teams aside from their regular jobs. Some will be asked to help for a few days; others will be asked to help for weeks or even longer. Some will help on a part-time basis; others may be pulled aside to work full-time on the implementation.

OHA staff, supervisors and managers not directly involved in CCO Implementation will play a key role ensuring resources are allocated appropriately and critical work outside of Transformation is completed. That means managers will work with staff to determine how routine work will be covered, prioritized or set aside. They will make decisions about what is most critical, what can wait, and what will stop, and will share those decisions upward to their division leadership.

We all will use the project management tools we have used over the past several years to ensure clarity of expectations, task completion, and accountability.

What it will look like on the ground

Workstream leads - The workstreams will be led by OHA executives. They will be accountable for the specific scope of work and the daily activities of their workstream. To accomplish the work, the workstream leads will convene temporary teams of OHA and where applicable DHS staff to accomplish the work required to support Coordinated Care Organizations. The workstream leads will be creative in building these teams to meet their objectives and reach outside traditional structures to find staff talent to get the job done.

Team leaders – Team leaders will work closely with their workstream leads and have an important responsibility. Team leaders will be assigned by the workstream need rather than by traditional division or program hierarchy. They will be directly accountable to the workstream lead for their assigned body of work. In the context of this work, team members frequently will receive direction and support from leaders outside of their chain of command or regular supervisor. They will be accountable to their supervisor to support the workstream and prioritization of duties that may fall outside the workstream.

Team members – Team members will be key to our success. They will be assigned by the workstream team lead and will be responsible for tasks as assigned based on their experience, skill set and knowledge. They will be accountable to their team and workstream leads for these tasks. They are expected to be flexible and supportive of all of the work and to foster strong partnerships with team members across the Health Authority. In many instances, their team leads will be people outside of their normal reporting structure. Similarly, team members may receive direction and support in the context of this work from leaders outside of their chain of command or regular supervisor. Team members will also be accountable to their supervisor to support the workstream and prioritization of duties that may fall outside the workstream. In all instances, team members are expected to be flexible and supportive of the Transformation, collaborate with everyone with whom they are working across all parts of the Health Authority, and foster strong partnerships with other team members to accomplish the work.

Managers and Supervisors – As we meet our milestones, the tasks remaining for each workstream will evolve. Staff working on the implementation in April may be different than the staff involved in July or November. OHA managers and supervisors will have an important role in CCO Implementation. It will be their job to ensure that even as work is prioritized and resources are focused to meet the goals of the CCO Implementation, other activities are prioritized appropriately.

They will be responsible for managing their staff resources to support the project without unduly straining existing staff. While CCO Implementation is the agency's top initiative, there are other core functions that must be maintained and supported. Managers will be expected to prioritize and manage workload and also to alert their supervisors if CCO implementation prioritizes conflict with other critical agency functions.

Health System Transformation / Coordinated Care Organizations Implementation Workstreams

Workstream charters are being finalized and workstream teams are being convened. Teams will evolve as the project moves forward.

Executive Steering Team

Judy Mohr Peterson, Executive Sponsor

Kelly Ballas, Jeanny Donovan, Tina Edlund, Linda Grimms,
Linda Hammond, Suzanne Hoffman, Cathy Kaufmann, Mel Kohn,
Carolyn Lawson, Gretchen Morley, Susan Otter, Tricia Tillman, Patty Wentz

Workstream: CMS Waiver & Designated State Health Programs (DSHP)

Leaders: Tina Edlund & Kelly Ballas

Scope: This team will work to ensure the approval of the State's request for amendments to and extension of the 1115 Demonstration and request for approval of federal financial participation (FFP) for Designated State Health Programs (DSHP) submitted to CMS on March 1, 2012.

Workstream: Procurement/Requests for Applications (RFA)

Leaders: Kelly Ballas & Linda Grimms

Scope: The overall goal of this group is to develop policies and processes to procure for and contract with CCO applicants, including:

- Developing CCO application and evaluation guidelines, negotiation plans for CCO procurement, CCO contracts.
- Maximizing the use of technology and developing a new web portal procurement process to support the CCO procurement process.
- Developing a plan for MCO contracting during the CCO implementation process.
- Coordinating the work described above to ensure that supporting OARs and business processes align with CCO implementation.

Workstream: Finance/Global Budget

Leader: Kelly Ballas

Scope: The finance implementation workstream is tasked with budgeting and payment for Medicaid services that supports the transformation goals of:

- Transitioning beneficiaries and eligible Medicaid services into CCOs,
- Providing CCOs with maximum flexibility to invest in efficient and effective care including new services and supports not previously reimbursable such as non-traditional health workers.
- Ensuring that rates and payments incent improved health outcomes and equity, and;
- Controlling the growth of Medicaid spending to a fixed rate over time.

In addition the workstream will assist the Medicare and Medicaid Alignment workstream and CMS to ensure alignment of Medicare and Medicaid payment structure for individuals who are dually eligible for both programs.

Workstream: Member Transition

Leader: Cathy Kaufmann

Scope: Current and new OHP members must be effectively and efficiently transitioned from MCOs and FFS into CCOs as they emerge. This transition must respect member’s rights; preserve continuity of care; minimize confusion among members and providers; and reduce the administrative burden to OHA and CCOs, as well as providers and partner agencies. This workstream will:

- Develop a work plan to implement member transitions on a region-specific basis (as CCOs emerge);
- Develop comprehensive enrollment scenarios (including those for special populations or circumstances) and determine the process(es) for enrollment for each;
- Identify system changes, including in MMIS and the Client Maintenance system, required to support enrollment processes;
- Identify system changes, including MMIS and Member Maintenance, required to support enrollment processes;
- Identify any required changes to policies, OARs, and contract requirements required to support enrollment processes; and,
- Work with the Communications Workstream to identify communications needs for members and staff related to enrollment changes.

Workstream: Community Development & Readiness

Leader: Cathy Kaufmann

Scope: OHA will be an active partner in health care transformation and support communities as they consider and begin to develop CCOs. Once formed, CCOs will need time, support and technical assistance to fully realize the goals envisioned by health system transformation. This work stream directs, develops, implements and/or coordinates a variety of efforts designed to support community readiness for health system transformation, as well as the success of CCOs

once they are formed, including: Innovator Agents; technical assistance and other support in the development and meaningful engagement of Community Advisory Councils (CACs); technical assistance and support in working with community stakeholders and in developing the community needs assessment; culturally-appropriate community outreach; Patient-Centered Primary Care Homes (PCPH); Learning Collaboratives; and Non-Traditional Health Workers. This workstream will assist CCOs, their provider networks and their communities to promote active and representative participation among all community members.

Workstream: Delivery System (MCO/CCO Transition)

Leader: Jeanny Donovan

Scope: The Delivery System Transition workstream will develop strategies, a policy framework and time-lines to ensure the managed care delivery system remains stabilized during the transition from MCOs to CCOs. Efforts will include:

- Assessing the potential delivery system impacts following receipt of Letters of Intent (LOI) and adjust planning accordingly;
- Developing an MCO monitoring plan to ensure the access, continuity and quality of care) for enrollees is protected during the transition process;
- Establishing a time-line and amending/renewing MCO (FCHP, MHO, DCO, and PCO) contracts and administrative rules addressing new applicable CCO requirements and certain rights and responsibilities as identified in HB 3650; and,
- Developing contract language and assuring appropriate linkages and agreement between the Contracts, Administrative Rules, OHPB Implementation proposal and the Legislation.

In addition, the workstream will develop strategies for moving non-emergency medical transportation services for CCO enrollees from the fee-for-service delivery system to CCOs and work with Tribal representatives to ensure that concerns outlined in their letter to the Oregon Health Policy Board dated January 9, 2012 are addressed in CCO Implementation.

Workstream: Operations / Internal Support

Leader: Linda Hammond

Scope: This work requires accessing necessary staff resources to align all relevant operational functions and processes to support the CCO Implementation.

This includes:

- All divisions, units, teams, functions, procedures, systems, and processes in OHA & DHS that will be impacted by the implementation of CCOs and,

- Workforce Training and Development as a result of needed redesigned business operations.

Additionally, this workstream will bring Change Management strategies tailored to inform, support and include staff members throughout the operational changes.

Workstream: Medicare and Medicaid Alignment

Leader: Susan Otter

Scope: This workstream will include oversight, coordination, and implementation of Health System Transformation issues that relate to integrating services for dually eligible individuals, by integrating processes and requirements for Medicare and Medicaid plans to make the experience of care seamless for beneficiaries and simpler for providers and plans. In addition, this team is responsible for oversight, coordination, and implementation of shared accountability mechanisms between CCOs and the long term care (LTC) system for individuals served in both systems.

The workstream is also responsible for carrying out the CMS Design Contract, including: preparing a proposal for a State Demonstration to Integrate Care for Dual Eligible Individuals, leading negotiations with CMS related to Oregon’s participation in the CMS Medicare/Medicaid Alignment Demonstration, administering the CMS Implementation Contract (should the Demonstration proposal be successful), and coordinating the procurement process for three-way contracts between CCOs, CMS and Oregon.

Workstream: Quality and Accountability

Leader: TBD

Scope: This workstream will lead the planning and execution of a quality strategy and oversight plan for CCOs and MCOs. This includes development of quality improvement plans and a monitoring system for CCOs. This workstream will develop the core metrics of coordinated care organization performance and will include development of the principles and framework for metrics selection established by the Incentives and Outcomes Committee and the Quality Metrics group. Metrics will include measures of integration for physical and behavioral health and system efficiency.

Cross-Cutting Workstreams

Workstream: Communications

Leader: Patty Wentz

Scope: There will be an overall communications strategy and all communications activities will be accountable to that strategy. The plan will encompass all internal and external communications to agency staff, OHP members, providers, plans, counties, community members, and media. The communications plan will be based on the milestones for public process, the activities occurring to build the CCOs and OHA Change Management. It will use all available communications channels to reach the wide and diverse audience affected by health system transformation and the general public. It will be designed to build maximum transparency and engagement into the CCO process and build momentum for CCOs that meet the vision of HB 3650 and SB 1580, including Patient-Centered Primary Care Homes (PCPCH), health equity, and electronic health record adoption. Program and leadership staff across OHA and DHS will assist in informing and executing communications activities.

Workstream: Health Analytics

Leader: Gretchen Morley

Scope:

- *Internal OHA needs:* Assist workstream teams to identify internal data needs and solutions to support CCO implementation;
- *External CCO needs:* Identify need and provide data required externally for CCO implementation;
- *Metric support:* Provide support for the selection, collection, and definition of CCO performance metrics; and,
- *Coordinated Website Approach:* Identify and implement a coordinated and robust approach to providing data and analyses through the OHA website.

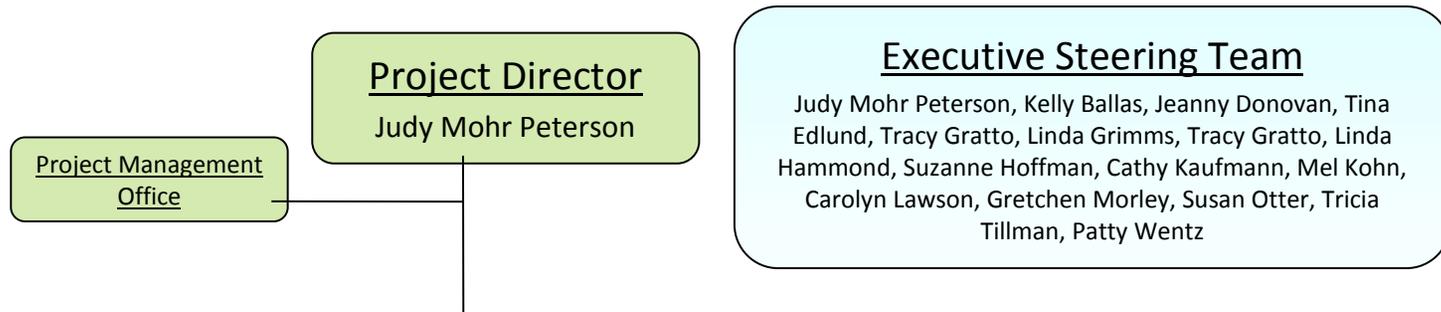
Workstream: Information Systems

Leader: Carolyn Lawson

Scope: Each CCO Implementation workstream will include a defined Office of Information Systems (OIS) scope, focused on transformation objectives, which will support both immediate and longer term goals. OHA OIS will provide resources, assistance, and options to support the objectives of each workstream. OIS is committed to providing an overall integrated approach for information management, improved technology, and is also committed to deliverables that will create a sustainable and flexible operational state that focuses on transformation at all levels of the organization.

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CCO Implementation Workstreams



Workstreams

- CMS Waiver – Tina Edlund
- Procurement / Requests for Application – Kelly Ballas & Linda Grimms
- Finance/Global Budget – Kelly Ballas
- Member Transition – Cathy Kaufmann
- Community Development & Readiness – Cathy Kaufmann
- Delivery System (MCO/CCO Transition – Jeanny Donovan
- Operations/Internal Support – Linda Hammond
- Medicare and Medicaid Alignment – Susan Otter
- Quality and Accountability - TBD

Cross Cutting Workstreams

- Communications - Patty Wentz
- Information Systems - Carolyn Lawson
- Health Analytics - Gretchen Morley

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Coordinated Care Organizations

March 2012 fact sheet

A more person-centered and affordable health system for Oregon

Coordinated Care Organization definition

A Coordinated Care Organization (CCO) is a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid).

What will stay the same and what will be different with Coordinated Care Organizations

Under CCOs, the Oregon Health Plan's medical benefits will not change. But today the system separates physical, behavioral and other types of care. That makes things more difficult for patients and providers and more expensive for the state.

CCOs will have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. CCOs will be able to better coordinate services and also focus on prevention, chronic illness management and person-centered care. They will have flexibility within their budget to provide services alongside today's OHP medical benefits with the goal of meeting the Triple Aim of better health, better care and lower costs for the population they serve.

How Coordinated Care Organizations will work

CCOs will be local. They will have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs will be accountable for health outcomes of the population they serve. They will be governed by a partnership among health care providers, community members, and stakeholders in the health systems that have financial responsibility and risk.

Status of Coordinated Care Organizations

Across the state, care providers, hospitals and health care plans are coming together to apply to become Coordinated Care Organizations. The first CCOs should be launched by August 1, 2012. There will be four open application periods for CCOs in 2012.

Key milestones

April 2, 2012	Non-binding letters of intent due to OHA from all potential 2012 CCO applicants (no matter when they intend to apply through the year)
April 30, 2012	Technical applications due to OHA from potential CCOs for first period
May 14, 2012	Financial applications due to OHA from potential CCOs for first period
May 28, 2012	First CCOs certified and enter CMS approval process
Aug. 1, 2012	First CCOs launched

See www.health.oregon.gov for timelines for subsequent application periods.

How CCOs will be chosen

The request for applications (RFA) lays out detailed criteria for potential CCOs. The RFA can be found at www.health.oregon.gov. The Oregon Health Authority is responsible for selecting local CCOs.

Potential CCOs will be measured on their ability to:

- Develop and implement alternative payment methodologies that are based on the Triple Aim of improving health, health care and lowering costs;
- Coordinate the delivery of physical health care, mental health and chemical dependency services, and oral health care;
- Engage community members and health care providers in improving the health of the community and addressing regional, cultural, socioeconomic and racial disparities in health care that exist among the OHP clients/CCO members and in the CCO's community;
- Progress from the baseline requirements for CCOs to the full requirements expected at maturity;
- Manage financial risk, establish financial reserves and meet minimum financial requirements; and
- Operate within a fixed global budget.

Public process in creating CCOs

The request for applications requires each CCO applicant to hold a public information session in its local community. Additionally, all non-binding letters of intent and technical applications from potential CCOs will be posted online at www.health.oregon.gov.

Information for Oregon Health Plan clients

OHP clients will be notified at least 30 days in advance of any change in health plans, but the Oregon Health Authority will be going above and beyond standard notices. Special outreach and communications will be created for Oregon Health Plan clients about CCOs, what to expect with the coming change and how to use CCOs for better health and care.

Background on how CCOs were created

CCOs were created in response to escalating health care costs, due in large part to an inefficient health care system. Over two legislative sessions, in 2011 and 2012, Governor Kitzhaber and bi-partisan lawmakers passed landmark legislation. More than 1,200 Oregonians provided input through eight community meetings that were held around the state, and another nearly 200 people met in work groups to help create the framework for CCOs.

Reducing costs while improving care

A third-party analysis found that by implementing CCOs, Oregon could save a significant portion of projected Medicaid costs in the short and long terms. Savings in state and federal dollars would be more than \$1 billion within three years and more than \$3.1 billion over the next five years.

Interested potential CCOs that have questions about the application process should contact the OHA Office of Contracts and Procurement at RFA.FormalQuestions@state.or.us.

Transforming the Oregon Health Plan through Coordinated Care

April 2012



What we will cover

- OHP Health System Transformation: Moving forward
- Why change is necessary
- Coordinated Care Organizations: Basics
- Federal Partners
- Timelines

CCOs moving forward

- “Request of Application” available for potential Coordinated Care Organizations.
- Dozens of entities in all corners of state have filed non-binding Letters of Intent
- First CCOs will be up and running in August

Senate Bill 1580

Launched Coordinated Care Organizations

- Follow up to 2011's HB 3650
- Strong bi-partisan support
- A year of public input – more than 75 public meetings or tribal consultations
- Built on 1994's Oregon Health Plan that covers 600,000 Oregonians today

Why transform

Unsustainable:

- Health care costs are increasingly unaffordable to individuals, businesses, the state and local governments
- Inefficient health care systems bring unnecessary costs to taxpayers
- When budgets are cut, services are slashed.
- Dollars from education, children's services, public safety
- 2014: as many as 200,000 Oregonians will be added to OHP

Cost: if food were health care

If food prices had risen at the same rates as medical inflation since the 1930's:

✓ 1 dozen eggs	\$80.20
✓ 1 roll toilet paper	\$24.20
✓ 1 dozen oranges	\$107.90
✓ 1 pound bananas	\$16.04
✓ 1 pound of coffee	\$64.17

Total for 5 items \$292.51

Source: American Institute for Preventive Medicine 2007



The complicated puzzle

- 85 percent of OHP clients:
 - 16 managed care organizations
 - 10 mental health organizations
 - 8 dental care organizations.
- Remainder: “fee-for-service” arrangements between the state and local providers.
- No incentives or payment codes for health
- Estimated 80% of health care dollars go to 20% of patients, mostly for chronic care

Cost of fragmentation

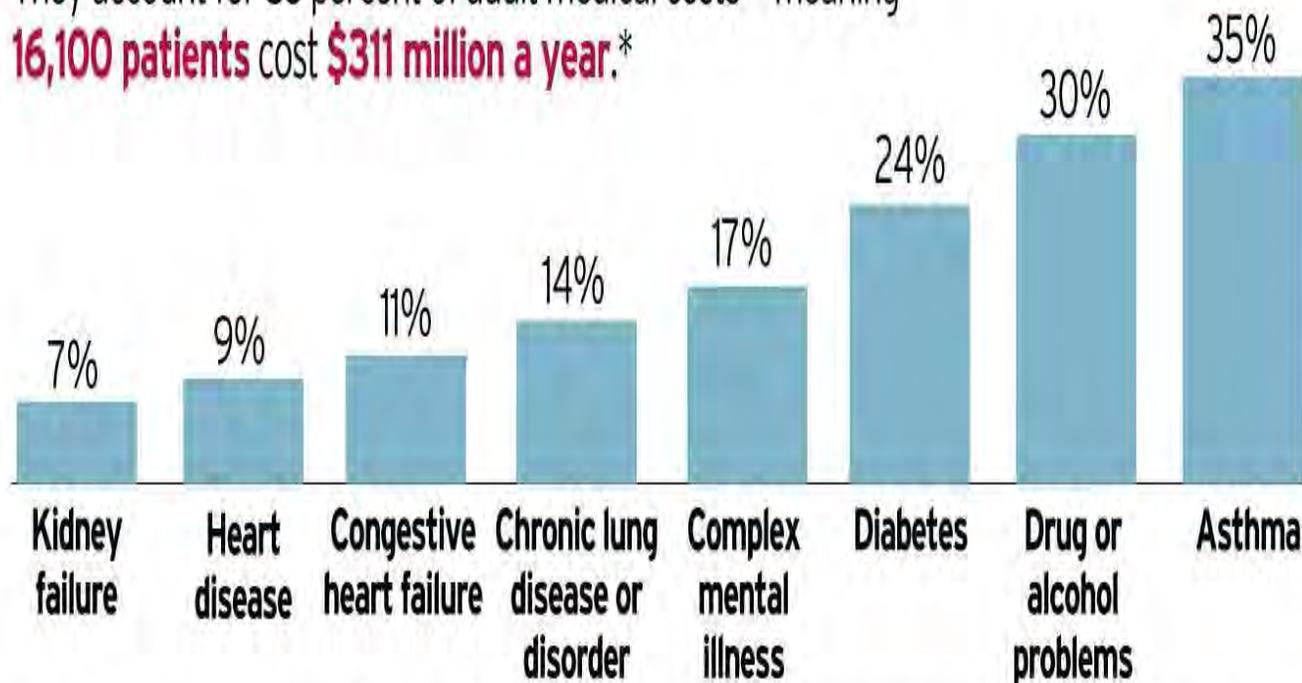
- Behavioral health major driver of bad outcomes and high costs
 - Human and financial cost
- Chronic conditions
 - Care delayed is too often care denied

Frequent adult hospital users

Most common health problems of the 25 percent of Oregon Health Plan adults managed by CareOregon.

They account for 83 percent of adult medical costs -- meaning

16,100 patients cost **\$311 million a year**.*



Average age 46 years

Percent female 68%

Non-maternity hospitalizations 8,471

Emergency room visits 43,460

Annual average per member \$19,470

*CareOregon manages care for 160,000 of the 600,000 adults and children on the Oregon Health plan.

Source: CareOregon

DAN AGUAYO/THE OREGONIAN

We can do better:
Coordinated Care

Flexibility: pay for non-traditional health workers and other means to coordinate care

Addressing behavioral health: Reduced ED visits by 49% and reduced costs per patient \$3,100.

Central Oregon pilot project

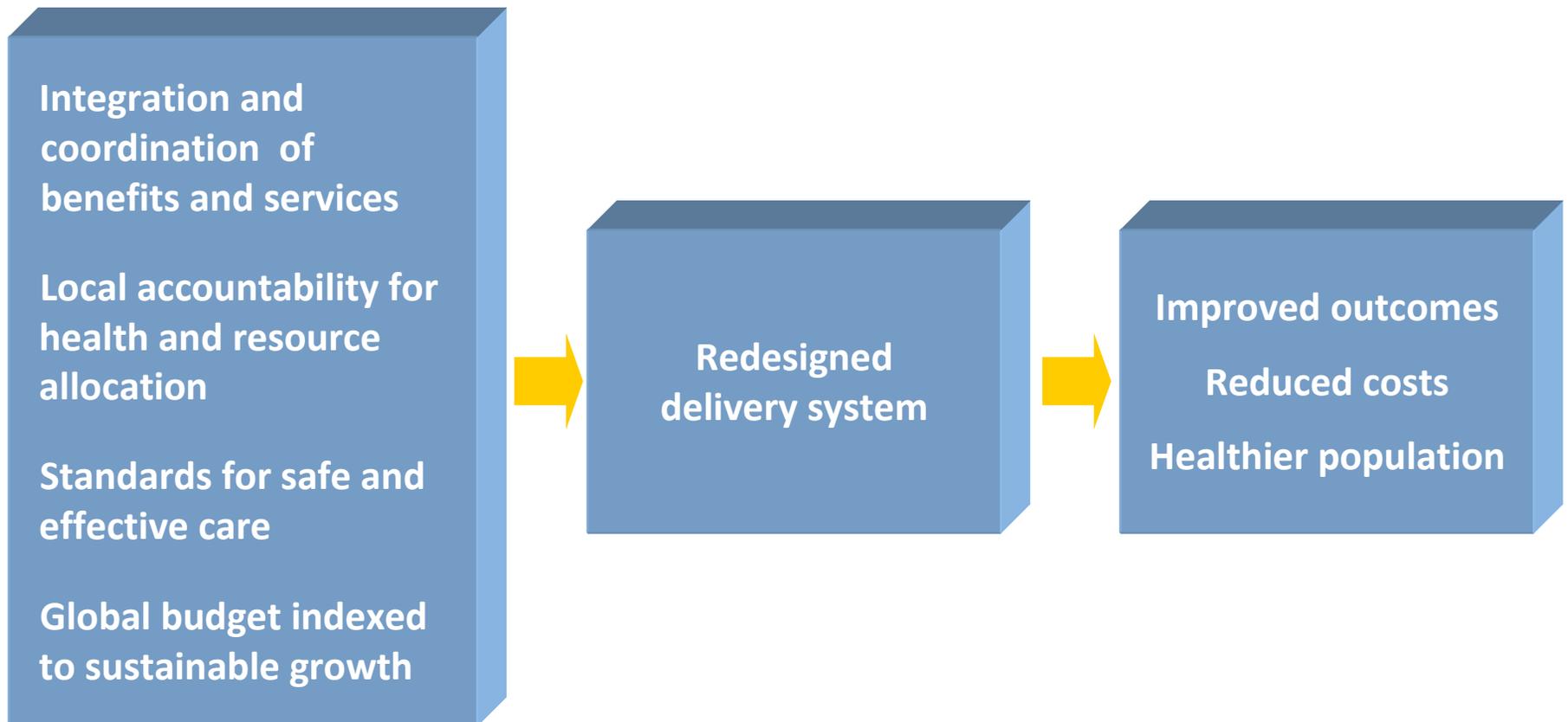


GOAL: Triple Aim

A new vision for a healthy Oregon

- 1 Better health.
- 2 Better care.
- 3 Lower costs.

Vision of Coordinated Care



Coordinated Care Organizations

Replace today's MCO/MHO/DCO system

Local health entities that deliver health care and coverage for people eligible for Medicaid (the Oregon Health Plan).

- ✓ Local control
- ✓ One point of accountability
- ✓ Global (single) budget
- ✓ Community health workers
- ✓ Patient-centered primary care homes
- ✓ Expected health outcomes
- ✓ Health Equity
- ✓ Integrate physical and behavioral health
- ✓ Focus on prevention
- ✓ Reduced administrative overhead
- ✓ Electronic health records

CMS Medicare/Medicaid Alignment Demonstration

- 3-year demonstration project in many states
- Oregon's way will be through CCOs
- Key features:
 - Align Medicaid and Medicare requirements
 - Passive enrollment of dually eligible individuals in CCOs (with opt out option)
 - Blended Medicare/Medicaid funding and flexibility around spending
 - Integrated Medicare/Medicaid benefits

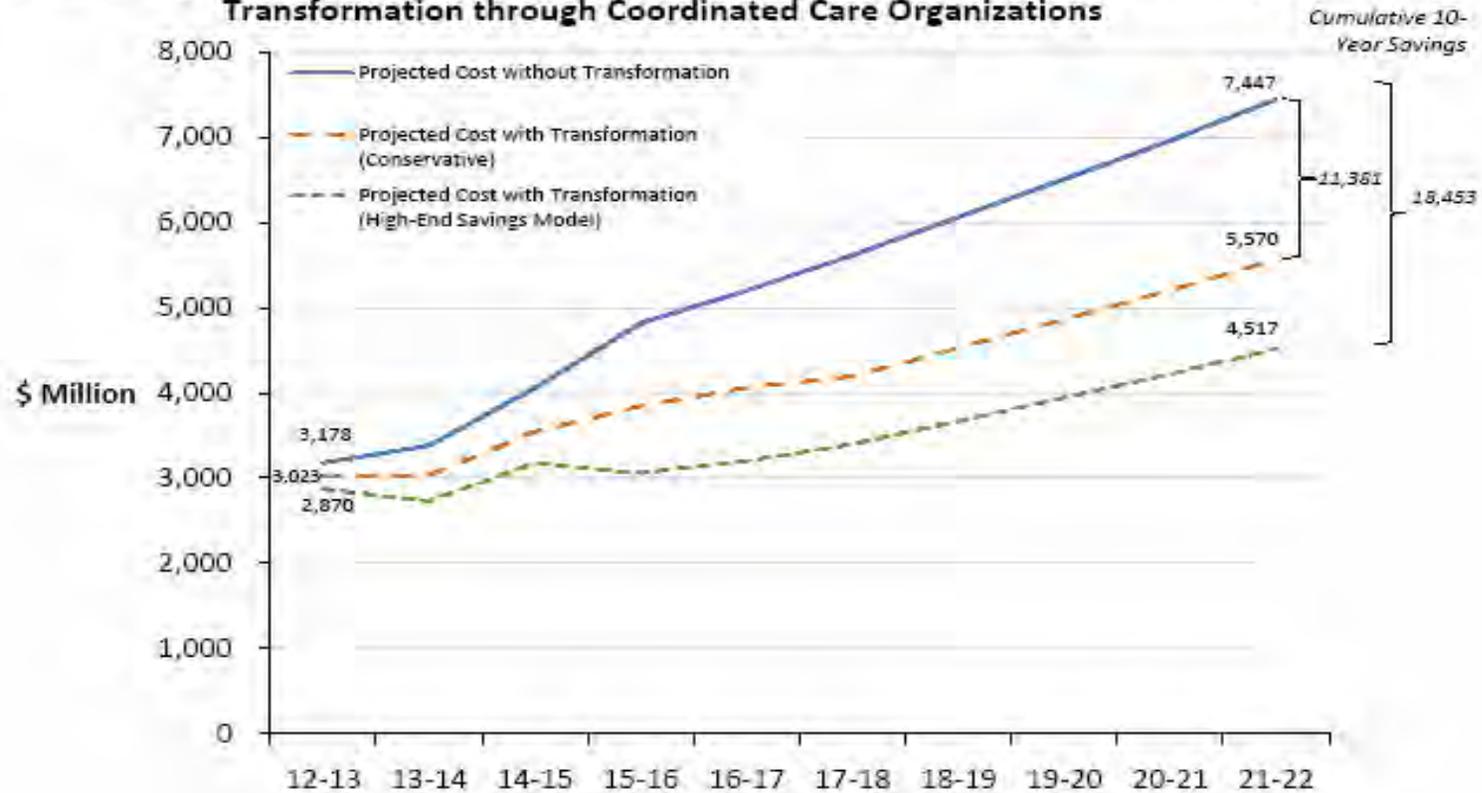
Ted Hanberg, 83, was in and out of the hospital until a coordinated care team helped him get congestive heart failure under control

Since then he hasn't had a return to the hospital in six months and is living independently with his wife and daughter.



Cost of doing nothing

Health Management Associates' Annual Projected Savings Attributable to Health System Transformation through Coordinated Care Organizations



Source: Health Management Associates

Notes: Health Management Associates' projections end in 2019. The 2019-2021 biennium and 2021-2022 state fiscal year were extended forward by the Oregon Health Authority by applying the growth rates in HMA's model.



Lower costs

Reducing costs while improving care

- A third-party analysis
- Savings would be more than \$1 billion total fund within three years and more than \$3.1 billion total fund expenditures over the next five years.

Federal partnership

- Approximately 60 percent of Oregon Medicaid dollars are paid by the federal government
 - Waiver
 - Financial investment
-

For Oregon Health Plan Members

- Nothing is changing today
- The first CCOs will be up and running in August 2012
- OHP Members will receive **at least** 30 days notice if care is moved to local CCOs
- Most OHP members will likely not see much change
- Members with chronic illnesses will have more support to help them manage their care
- CCOs are required to have a Community Advisory Council and public information sessions
- OHA staff are ready to help with any questions

What isn't changing

- Oregon Health Plan medical benefits, co-pays or premiums will not change. CCOs will administer OHP as part of their contracts.
- The Prioritized List of Oregon Health Plan Benefits will not change

Next steps

Timeline – CCOs

As of April 4, 2012

Technical Applications from CCOs due (Wave one)	April 30
Financial Applications from CCO due (Wave one)	May 14
New CCOs Certified	May 28
Medicaid Contracts signed with new CCOs	By June 29
CCO-Medicaid Contracts to CMS	By July 3
Medicaid Contracts effective for new CCOs	August 1

Timeline

Medicare-Medicaid Integration

As of April 4, 2012

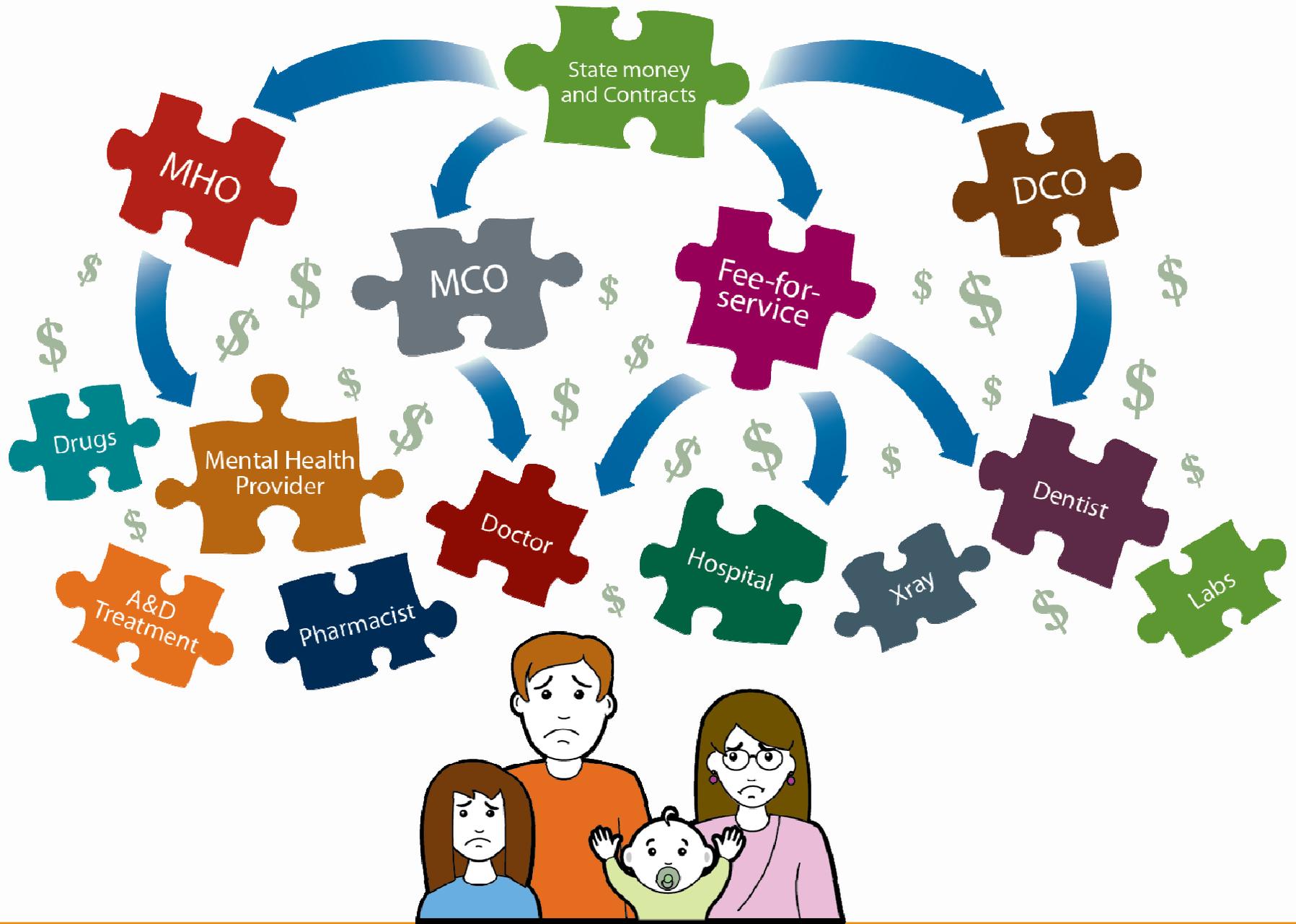
Final Medicare-Medicaid Integration Proposal submitted to CMS	April 12
Medicare-Medicaid Integration benefit package due to CMS	June 4
CMS and OHA certification for Medicare-Medicaid Integration	July 31
3-way contracts signed	Sep 20
Medicare-Medicaid Integration 3-way Contract effective	Jan 1, 2013

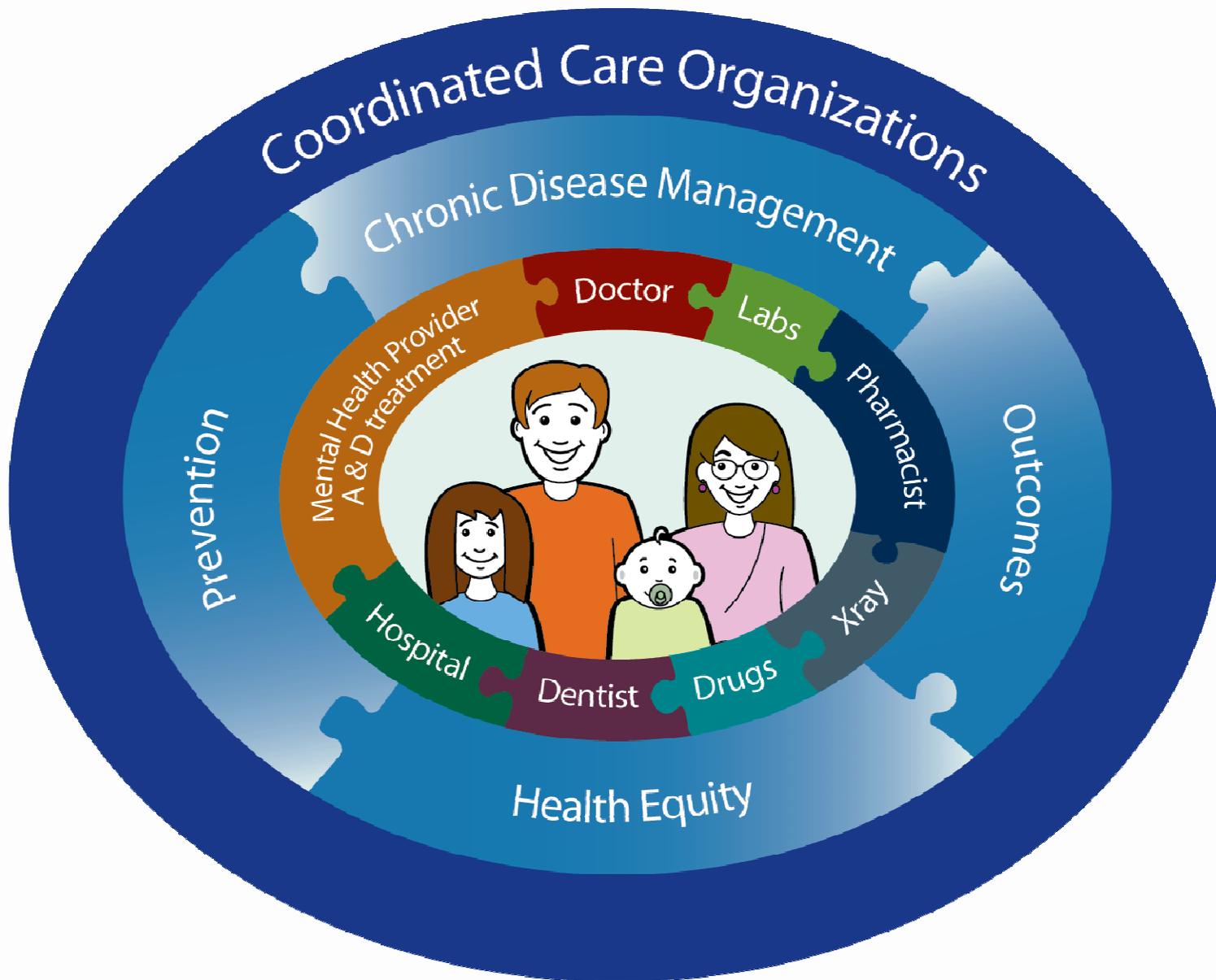
Questions about Request for Application?

During the procurement process:

Please send an email to:

RFA.Formalquestions@state.or.us







www.health.oregon.gov

