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CC: "Bennett, Rick" <RBennett@aarp.org>, "Shrestha, Bandana" <BShrestha@aarp...>
Date: 3/7/2011 8:51 AM
Subject: AARP Comments/Feedback to OHSTT

AARP Oregon Comments and Feedback to the Oregon Health Systems Transformation Team

Provided by Gerald J. Cohen, J.D., M.P.A., AARP Oregon Senior State Director

March 7, 2011

AARP has completed an initial review of the draft legislative concept just shared publicly with the Team. Listed below are a series of questions and concerns these raise. Following these discrete comments, we are also providing to the Transformation Team what we had previously shared publicly with the Oregon Health Policy Board on February 8, 2011 (the first briefing the Board has received regarding Oregon's Home & Community-based system). We hope that there will be further briefings and field visits to better learn and appreciate Oregon's model of Home & Community-based Care System (HCBS): its values, operations and why Oregon is seen as the "model" sought after by other states and HHS.

Questions/Comments regarding the Concept:

* Is participation in an ACO mandatory or voluntary for (a) Medicaid, (b) Medicare and (c) the dual eligibles? §414.725(f)(6) references a notice to members after "assignment" to the ACO and (f)(7) references "prospective" enrollees, but Synopsis (page 1) indicates that an essential element is "choice, independence and dignity".

* Whether mandatory or voluntary, will individuals have a choice among ACOs? If so, what's the minimum number of ACOs for each region or community of the state?

* What standards will ACOs be held to in the creation and maintenance of their provider networks? We would stress that quality should be the primary factor. Unless this is specified, an ACO working on a capitated basis may be inclined to build a provider network based on low bids.

* There is no indication as to what rights and remedies consumers will have or the process by which they will be allowed to exercise these rights. We would favor a system that allows consumers to leave or switch ACOs freely since this would encourage robust competition and high quality medical and consumer service. For denials or delays in service, there should be a very speedy appeal system with an independent review by an entity able to order immediate corrective action when appropriate. A system to assist consumers such as an independent ombudsman or access to legal representation would be appropriate. An please note that in 2006, AARP provided to a DHS Work Group under the Task Force for the Future of Seniors and Persons with Disabilities convened to explore better long term care integration via "managed care" options with a set of consumer protections we recommended. We have subsequently shared these again with DHS in January 2011.

* There are several references to collecting quality information (§ 414.018(2) (f), ORS §414.xxx (5,)) but no mention of consumer satisfaction or timely access to care as measures. Also there is no indication as to how this information will be used if there are deficiencies.

* ORS §414.xxx (2) (b) is overly narrow as to transitional care - limited to entering or leaving a hospital or skilled nursing facility. Transitional care is appropriate whenever there is a change in care setting or a significant change in providers.

* ORS §414.xxx (2) (e) on safeguards is also limited and should include inappropriate delays in providing access to services, including social supports to consumer and family.

* ORS §414.xxx (3) stress that the ACO should reduce the use of emergency rooms and hospital readmissions. Better language would be reducing "avoidable ER and hospital admissions."

* ORS §414.xxx(5) on quality indicators could be expanded to include evaluations of timely access to care, reductions in disparities in access and outcome based on race or ethnicity, and consumer satisfaction. This section and ORS §414.xxx (6) could be expanded to require ACOs to use objective quality information in the selection of the direct care providers for inclusion in their networks and to the removal of providers if assessments show deficiencies in quality.

* § 414.760 indicate that ACOs will be required to implement primary care homes "to the maximum extent feasible." Under what circumstances would an ACO not be required to provide a primary care home? What substitute care management systems will be allowed?

* The section on necessary federal approvals (unnumbered) does not specify whether a Medicare waiver is being requested for all beneficiaries or just the dual eligibles (or a subset, thereof). This should be clarified as well as the issue as to whether the intent is to force Medicare beneficiaries and/or the dual eligibles into ACOs.

* §414.025(13) Quality measures definition is narrow and references "nationally accepted performance metrics." Which ones? How will the other quality indicators - consumer satisfaction, etc. - be included?

A final comment regarding the preliminary synopsis and its primary sources used to develop the legislative concept: there appears to be little to support the inclusion of long-term care services and supports into the integrated health systems being proposed. The OHPB's Action Plan for Health neither makes any mention of long-term care nor the home- and community-based services associated with Oregon's LTC system. The meetings and discussions of the Health System Transformation Team have focused primarily on medical/acute care and mental health issues such as avoidable hospitalization and emergency use. The HSTT presentation on integrated

models provided no evidenced-based data that Medicaid Managed Care LTC (MMCLTC) provides cost savings and/or improves the quality of care or the health status of the individual. It should be noted that the several actions long-term care included in the Governor's Budget Report require federal waivers and CMS approvals that may be difficult to obtain and any budget savings attributed to the waivers/approvals should be considered tentative, at best. Finally, strictly focused on budgetary savings justifications, we fail to see how any "savings" that might allege to have accrued from these efforts would be re-invested in our home & community-based long term care system.

Summary of Comments provided to the Oregon Health Policy Board on February 8, 2011:

Oregon has a cost-effective long term care system that provides choice, independence and dignity to seniors and people with disabilities. It's a model that many states are looking to in efforts to shift from institutional care to home- and community-based services. While we must focus on the impact of an aging population and develop strategies to address that impact, we should be cautious in how we move forward to avoid unintended consequences that negatively impact Oregonians of all ages, and devalue Oregon's nationally recognized model.

Governor Kitzhaber's diagnosis of the ills of our health care system is solid, but the prescription must be evidence-based and "do no harm." We cannot afford to risk dismantling or severely damaging a system that is highly effective (our long term care/home & community-based system) to help a dysfunctional system (acute and primary care).

State policymakers should not have a false sense of security that they can sign a contract with a managed care company, pass on the responsibility and keep a lid on costs. Ultimately the state will still be responsible for quality and cost. Managed care should be explored with caution and no one should be counting on it as the magic bullet for controlling long term care costs over time.

When applied to long-term care, AARP favors the concept of managed care based on a medical home model with care managed and coordinated by a physician or medical group practice, operating independently from providers

of long term care, and with the mission of coordinating care across all providers and settings (physicians, hospitals, clinics, residential settings, nursing homes, home care, etc.) to provide the individual with the best care in the setting that ensures the maximum appropriate level of independence. Provider networks should be constructed based on objective data on quality and should be broad enough to ensure that individuals are able to obtain appropriate care within their own communities.

However, there are also a number of risks:

- Service and quality reductions - To stay within the capitated rate, contractors have an incentive to squeeze providers who in turn have an incentive to reduce services or skimp on quality. This is a particularly concern in the current budget environment where providers are already being squeezed and there have already been arbitrary, across the board cuts to home care hours and other long term care services.
- Continuity of care and stability of the network - If contractors are constantly shopping for the cheapest provider and the provider network is not stable - this can hurt consumers - by for example forcing them to move from one care provider or facility to another.
- No guarantee of cost savings-Studies on the cost-effectiveness of Medicaid Managed Care LTC programs is mixed and inconclusive. The danger is that you would be adding another layer of bureaucracy between the state and LTC/HCBS providers without adding value.

Opportunities under Affordable Care Act:

AARP's Public Policy Institute has noted that there other options that might improve the coordination of care without fully integrating (or merging) as a capitated program our LTC/HCBS system with other systems (medical and/or mental health).

First, the Affordable Care Act of 2010 offers several opportunities and funding including:

1. Hospital Readmission Reduce Incentives (Sec 3025)
2. National Payment Bundling pilot focused on bundling for episodes of care (not just DRGs) (Sec 3023)
3. Community-based Care Transitions program promoting partnering with

community-based organizations (Sec 3026) that builds on Aging & Disabilities Resource Centers (ADRC) approach already piloted in Oregon.

4. Independence at Home Demonstration starts in 2012 with Medicare paying for house calls and a focus upon chronic care (Sec 3024)

5. Community Health Teams created to support interdisciplinary team infrastructure and address workforce needs for medical homes model (Sec 3502)

6. Medicaid Health Homes for Chronic Conditions includes 90% federal match (Sec 2703)

7. Community First Choice as new 1915 k waiver (Sec 2401)

8. Prevent Chronic Diseases (Sec 4108) with links to Medicaid Health Homes

Consumer Choice: AARP finds that this is a paramount feature. Those directly affected are best able to gauge the adequacy, quality and customer service provided by a health care system. Market competition provides a direct and immediate way of ensuring good quality that, from the consumer perspective, is far superior to government oversight and retrospective review. If consumers have choice in selecting from an array of managed care plans and the ability to change plans, the plans will be highly motivated to provide quality care. Conversely, if plan enrollees are captives, there is little motivation to provide high quality or good customer service. We probably all have has some experience with monopolies that we had to deal with that provided poor quality or customer service (cable, phone, DMV, IRS, etc.)

Accordingly, we support consumer choice, in the following decisions: (1) to participate in managed care; (2) to select from among competing managed care plans; and (3) to select among the direct care providers within a plans network. This could be coupled with financial incentives for plans and network providers tied on their ability to attract and retain consumers. In addition, government oversight should include "exit interviews" of consumers who leave plans to mitigate attempts to "lemon drop" those who have high medical needs.

Bottom line: AARP has long been an active supporter of initiatives to make health care more coordinated, integrated, and consumer- and outcome-oriented. We also support efforts to control healthcare costs through greater efficiency or systems changes that foster better care (e.g., reducing medical error and hospital readmissions, duplication of tests, and less use of institutional care when community care would be more

appropriate).

Combining improved care management and cost containment can best be achieved by careful balancing of systems to ensure quality and patient protection. Each proposed system and its component elements must be closely examined.

Thank you for the opportunity to respond,

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Person-Centered Behavioral & Physical Health Care Public Health & Prevention Regulatory and Population Health Health Management Services

March 4, 2011

Tina Edlund
Deputy Director for Planning and Policy Implementation
Oregon Health Authority

Dear Ms. Edlund

I have read the Legislative Concept Discussion Draft that was distributed to the Health System Transformation Team on March 2, 2011. As Benton County's Public and Mental Health Director, I fully support the goals as stated in Part 1 of the draft. That said, I am very concerned and dissatisfied that these very goals are not supported through the structure defined in the draft. While the document clearly states,

“Consumers get the care and services they need, **coordinated locally**..., **414.018 Goals; findings. 2 (d) People are at the center of coordinated care** and services delivered through accountable coordinated care contracts using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care;
(e) Communities and regions are accountable for improving the health of their communities, reducing avoidable health gaps among different cultural groups and managing health care and service resources;...”

no where in the document is local County Government called out as a partner with the State to support and assure this local, accountable and coordinated care. In fact, the document makes it very clear that local County Government is not in this system at all,

414.620 System established. (1) There is established the Oregon Accountable Health Care and Services System. The system shall consist of **state policies and actions**... The system should hold accountable care organizations and their providers responsible.....

It looks to me like ACO's would have no local accountability other than to “Work cooperatively with community partners to address public health issues;”

At the local level, coordination and integration of services for medically vulnerable populations; accountability for the health of our community; person centered care; and prevention focused systems are the cornerstones of our state's local mental health and public health programs. The County Board of Commissioners serves as the Local Public and Mental Health Authority with a responsibility for assuring a system of services and supports to address health needs within the County. Healthcare reform demands public accountability for public dollars, a share of this accountability should be at the local level. This legislative concept and any following legislation must include a clearly defined and central role for county government in assuring local accountability for the public dollars used for healthcare.

Thank you for providing this opportunity to comment on the draft.

Sincerely,

Mitch Anderson
Health Director

“Healthy People in a Healthy Community”

From: "Bob Nikkel" <RNikkel@jbh.org>
To: "Tina Edlund" <tina.d.edlund@state.or.us>
CC: <mike.bonetto@state.or.us>
Date: 3/6/2011 1:32 PM
Subject: Fwd: Health Systems Transformation Team Legislative
Conceptfeedback

Bob Nikkel

Begin forwarded message:

> From: "Bob Nikkel" <RNikkel@jbh.org>
> Date: March 6, 2011 12:56:58 PM PST
> To: <mike.bonetto@state.or.us>
> Subject: Fwd: Health Systems Transformation Team Legislative Concept
> feedback
>

> >> Mike,

>

> >> Here is my feedback on the first draft of the Transformation

> >> Committee's legislative concept using the outline of the

> >> "Preliminary Synopsis" document distributed March 2:

> >>

> >> Assumptions:

> >>

> >> Second bullet states that the LC uses existing statutory framework

> >> for ORS 414. We need a full examination of its relationship to ORS

> >> 426 (Civil Commitment) and ORS 430 (Community Mental

Health/Local

> >> MH Authority). To ignore this relationship is to further fragment

> >> the community mental health, addictions and developmental

> >> disability services system. While the system has been underfunded

> >> for many years, it is still the basic framework under which local

> >> communities and elected officials can maintain mutual

> >> accountability for all services, not just OHP mental health and

> >> chemical dependency services. Also, many (if not most)

> >> developmental disability crisis clients have co-existing mental

>>> health disorders which will be compounded by disconnecting or
>>> eliminating the ORS 426 and ORS 430 statutes from ORS 414.
>>>
>>> Key features:
>>>
>>> The definition of regional health authorities needs to be openly
>>> discussed and not left solely to the Oregon Health Authority for
>>> determination. This is a key structural component to health care
>>> and needs full public disclosure and broad input to determine
>>> boundaries, authority and characteristics of regional health
>>> authorities. Otherwise, we open ourselves to arbitrary and
>>> potentially biased decisions without adequate public accountability
>>> and oversight.
>>>
>>> The term "global budget" needs much more discussion. The term
>>> "global" can mean different things to different systems. Part of
>>> the reason (besides underfunding mental health and addiction
>>> services for decades in Oregon) for system fragmentation is that
>>> failures in the mental health and addictions services directly
>>> impact child welfare, juvenile justice, adult criminal justice,
>>> PSRB, school and work performance, and housing instability and
>>> homelessness. Too narrowly defined health care budgets and lack of
>>> linkages to other budgets (for the systems just delineated) will
>>> only lead to further resource disconnects and short-sighted
>>> incentives. Health care systems must think beyond health care
>>> risks and global budget definition is a crucial element that can
>>> lead to proper public expense incentives or cost shifting to other
>>> state and local resources. We need more discussion of what the
>>> "full continuum of care" really is, not what a narrowly defined
>>> health care cost definition will produce.
>>>
>>> As an illustration of this point, the MHOs have accepted increasing
>>> responsibilities for managing child/adolescent residential services
>>> (ie the Children's System Change Initiative); the child welfare
>>> Wraparound pilot projects; the Adult Mental Health Initiative
>>> (AMHI) for managing the costs of long-term civilly committed adults
>>> rather than maintaining them in institutional settings. The
>>> related budgets in child welfare, school, and state hospital
>>> services must get consideration in defining "global budgets."
>>>

>>> Under 414.018 Goals; findings: Again, this language does not
>>> adequately recognize or address the risks outside OHP health care.
>>> Need to add language that recognizes that costs include more than
>>> just health care costs within the Oregon Health Plan eligibility
>>> period. Remember, when individuals enter juvenile and criminal
>>> justice facilities and state hospitals, they lose (suspend at
>>> best) eligibility and costs are shifted to these other state GF
>>> supported agencies. The health care costs do not go away, they are
>>> shifted.

>>>

>>> Under (j) of this same 414.018 section: "ACO providers work [sic]
>>> are educated..." is a very critical feature and I support it but
>>> want to point out that it is meaningless unless there is attention
>>> and funding support given to increasing and improving the
>>> knowledge, skills, and attitudes for doing integrated health care.
>>> Our current inservice and professional/paraprofessional training
>>> programs do NOT currently do this and integrated care in the real
>>> world won't happen magically because we insert this language into
>>> the reform legislation. If it's just "feel good" stuff, then I'd
>>> suggest we be honest if we're not going to fund it and just delete
>>> it from the LC. But it is really important and I would strongly
>>> recommend making a point of talking about it when the legislature
>>> considers the bill to make sure it gets properly resourced and
>>> planned.

>>>

>>> 414.025 Definitions should be expanded or clarified to include
>>> residential services in Extended Care Projects such as Secure
>>> Residential Treatment Facilities.

>>>

>>> Also, there is no definition of "medications". Since in mental
>>> health, the costs of these components are estimated to be as high
>>> as 50% of the total of all other mental health services, there must
>>> be a definition and it should include a requirement for "medication
>>> optimization" as a way of promoting prescribing practices that are
>>> science-based and more likely to lead to improved long-term
>>> outcomes.

>>>

>>> 414.610 (3) should require the Oregon Health Authority to seek
>>> federal authorization for bundled payments and other payment
>>> reforms to lessen administrative and documentaion burdens that

>>> detract from time spent providing direct health and support
>>> services. It's not sufficient in this LC to direct the OHA to do
>>> this. This point would strengthen the effectiveness of language in
>>> 414.620 as well.

>>>
>>> 414.725 must require the state to set standards for the RFP process
>>> for "accountable care organizations" that are evidence-based and
>>> have a clearly defined relationship to other parts of the state
>>> and community systems that rely on integrated health care services
>>> being properly delivered. There must also be reference in this
>>> part of the LC to partnership and review/approval of ACOs by
>>> locally elected officials, primarily county commissioners who are
>>> defined under ORS 430 as the Local Mental Health Authorities.

>>>
>>> 414.760 (2) speaks to "feasibility" as a condition for assuring
>>> person centered primary care homes but the LC should spell out what
>>> the criteria for "feasibility" will be. Leaving this to the Oregon
>>> Health Authority does not provide adequate assurance of oversight
>>> and direction to a state agency that needs additional assistance in
>>> transparency of processes. Feasibility will be related to some
>>> degree to the lack of capacity in Oregon for primary care
>>> physicians, especially those who have the skills and attitudes
>>> needed to work with target populations who have the highest health
>>> disparities, highest morbidity and mortality rates, and with the
>>> most stigmatized disorders--mental health and addictions.

>>>
>>> 414.xxx NEW STATUTE for use of information sharing and
>>> confidentiality. This section needs much more content related to
>>> assuring that ethical (and not just legal) issues are attended to
>>> for people who should still have some right to a discussion about
>>> sharing sensitive health care information with any and all other
>>> providers. Just because HIPAA would allow the use of such
>>> information in a much more flexible manner, there is still a need
>>> to discuss how these information sharing processes work and some
>>> acknowledgement from clients/patients that they have been informed
>>> about these information sharing patterns. If a patient objects,
>>> that objection should be honored even if HIPAA would allow the
>>> sensitive medical information to be legally shared.

Response to Legislative Concept for Oregon Health Plan Accountable Care Organizations

In order to attain the goals identified in the Legislative Concept, two distinct organizational structures are necessary. As currently written, the Legislative Concept blends the functions of the Accountable Care Organization and Regional Health Authority as they are generally defined and made operational. Not only is there value in Oregon being in step with other states in conceptualizing this new model, there is also a need to separate the direct health care delivery role from those of planning and oversight to avoid the potential for conflicts of interest between these functions. Given that this is a publicly funded health insurance program and in this time of heightened scrutiny of state funding of programs, we need to avoid even the appearance of “the fox guarding the hen house”.

The distinction between the two organizational types can be summarized as follows:

The Accountable Care Organization is a coordinated system of health care providers, ranging from primary care to specialty medicine, behavioral health, tertiary care and long-term care. The ACO is collectively responsible for the health care outcomes of individuals who receive care from provider organizations affiliated with the ACO.

The Regional Health Authority provides planning, oversight and regulatory compliance of the ACOs operating within its region. The RHA is responsible for the health outcomes of a population through a systematic community-wide needs assessment; budget and payment methodology development; ACO contracting, payment and performance measurement; health information exchange development and measurement of community-wide outcomes.

The following proposed language changes illustrate how to differentiate these roles within the LC.

Part 1 – Goals and Policies

AMEND current statute.

414.620 System established. (1) There is established the Oregon Regional Health Authority and Accountable Care Organization System. The system shall consist of state policies and actions that make Accountable Care Organizations responsible for care management and the provision of health care and services for eligible persons, and Regional Health Authorities accountable for managing within a fixed budget by ensuring the provision of care so that efficiency and quality improvements address medical inflation and, to the extent possible, caseload growth and take these actions in a way that supports development for regional accountability for health, while maintaining the regulatory controls necessary to assure quality and affordable health services to all Oregonians.

(2) The Regional Health Authorities should pay for quality while managing within a global budget. The Regional Health Authorities should hold Accountable Care Organizations and their providers responsible for the quality and efficiency of care they provide, reward good performance and keep total spending to a global budget that limits cost increases. Within the Regional Health Authority system, restructured

payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered primary care homes.

Part 2 – Delivery System Changes

AMEND existing statute to describe procurement and requirements for Regional Health Authorities and Accountable Care Organizations.

414.725 Regional Health Authority contracts; financial reporting; rules.

(1)(a) Pursuant to rules adopted by the Oregon Health Authority, the authority shall execute Regional Health Authority contracts for integrated health care and services funded by the Legislative Assembly. ...

(b) It is the intent of ORS 414.705 to 414.750 that the Oregon Health Authority use, to the greatest extent possible, Regional Health Authorities receiving global payments to assure, through contractual arrangements with Accountable Care Organizations, integrated physical, dental, mental, chemical dependency, home and community based health and long term care and support services under ORS 414.705 to 414.750.

(c) The authority shall solicit qualified organizations that meet the standards established in ORS 414.xxx to be reimbursed for ensuring the provision of integrated covered services as part of an accountable and coordinated health system. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and any other qualified public or private entity that meets the qualifications for a Regional Health Authority. ...

For remainder of this section, replace “accountable care organization” with “Regional Health Authority”.

NEW STATUTE to adopt “ESSENTIAL ELEMENTS”, integration and accountability standards

ORS 414.xxx Essential elements for Regional Health Authority

Regional Health Authorities are responsible for the health outcomes of the population in their defined region. Each Regional Health Authority shall, at a minimum, have or obtain through contractual arrangement the following functional capacities in accordance with the standards and contracts established by the Oregon Health Authority:

(1) Regional Health Authorities improve the quality of care, lower cost, and improve health and well-being of the population in their region.

(a), (b) and (c) remain as written in the LC

(2) The Regional Health Authority assures provision of services designed to provide choice, independence and dignity:

(c), (d) and (e) as written in the LC become (a), (b) and (c)

(3) Quality indicators are evaluated to assess ongoing health status of individuals ...

(4) Regional Health Authorities demonstrate excellence of operations ...

ORS 414.xxx Essential elements for Accountable Care Organization

Accountable Care Organizations are responsible for the delivery of the full continuum of care for members receiving care from one or more of their affiliated provider organizations. Each Accountable Care Organization shall be contracted with one or more Regional Health Authorities and shall provide, at a minimum, the following functional capacities:

(1) Accountable Care Organizations are person-centered organizations that provide integrated person-centered care and services designed to provide choice, independence and dignity:

(a) and (b) remain as written in the LC

(2) Accountable Care Organizations prioritize working with ACO members with high needs and multiple chronic conditions ...

(3) The Accountable Care Organization's providers work together to develop best practices ...

(a) – (d) remain as written in the LC

NEW – Language for the service delivery expectations for individuals who are dually eligible

Replace “accountable care organization” with “Regional Health Authority” in this section

Part 3 – Related Implementation Recommendations

NEW STATUTE for use of information sharing and confidentiality

Replace ACOs” with “Regional Health Authority” in this section

NEW STATUTE Necessary federal approvals may be requested

Replace “ACOs” with “Regional Health Authority” in this section

Part 4- Key Definitions

Replace (10)“Accountable Care Organization” with the following:

Accountable Care Organization (ACO) – integrated care delivery system of health care providers responsible for the delivery, management and quality of care delivered to a specific population of patients enrolled with the ACO; which operates consistent with the principles of a person-centered primary care home.

Regional Health Authority (RHA) – entity accountable for the health of a population, that manages to a global budget and is responsible for contracting with and providing regulatory oversight of one or more ACOs. The RHA is accountable for improving the health of the community, reducing avoidable health gaps among different cultural groups and managing health care and service resources. The RHA contracts with ACOs using alternative payment methodologies that shift the focus to prevention, improves health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care.



Curry County Health and Human Services

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March 3, 2011

Tina Edlund
Deputy Director for Planning and Policy Implementation
Oregon Health Authority

Dear Ms. Edlund

I have reviewed the Legislative Concept Discussion Draft that was distributed to the Health System Transformation Team on March 2, 2011. From my viewpoint as both Curry County Mental Health and County Public Health Director, I can fully endorse the goals set forth in Part 1: **414.018 Goals**. While I fully endorse the goals and stated intent of the discussion draft, I am deeply concerned about the assumption that “Accountable Care Organizations” defined as “single integrated organizations” are the single or best way to achieve these goals. This concept poses a serious threat to the hundreds of existing integrative projects developed in most communities of our state while placing enormous sums of public money into untested, financially complex organizations.

At the community level, coordination and integration of services for medically vulnerable populations; accountability for the health of our community; person centered care; and prevention focused systems are the cornerstones of our state’s local mental health and public health programs.

County Mental Health programs have operated as accountable care organizations through our Mental Health Organizations for over a decade, albeit within a more limited sphere. We have accepted financial risk for psychiatric hospitalizations, for children’s residential care, and currently for long-term residential care of our most seriously mentally ill citizens. We have been successful in dramatically reducing the costs in each of these areas while improving the care of the target population and reinvesting all savings in improving access and quality of mental health care to a broader range of citizens. Transformation will either enhance (or maintain) these triple aim successes or could seriously damage the infrastructure that has attained them.

For example, fully capitated plans were instituted in Curry County in the past year. The southern plan typically delays payment for services to both our County Public Health and Addictions programs to the full extent allowed by contract. I am informed by our Hospital Administrator that the same is true for Hospital and clinic services offered by our local Health District. This has resulted in 2-3 week delays in payments to our local systems compared to fee-for service

payments by the state. The result is a loss of working capital for services while the Managed Care entity earns interest on public funds. Given the potential enormity of funding, I would suggest a prohibition on the ability of “accountable care organizations” earning interest on public funds resulting from delayed payments for services provided.

I would also suggest stronger and clearer language to replace “an ACO may include an alternative innovative integrated health and services arrangement approved by the authority in accordance with ORS 414.725.” In Southern Oregon, the majority of existing MCO’s, DCO’s and the regional MHO (Jefferson Behavioral Health) have begun a collaborative process that includes County mental health, addiction programs, social service programs, consumers, residential programs, county public health programs and others to identify and partner on targeted “accountable care projects.” This model of service delivery will build upon the existing strengths and expertise of the partners. There would certainly be an ability to collectively share risk, accountability and management. This regional initiative would support locally-based projects within the region as well as broader efforts when appropriate. A state-led imposition of an ACO is not likely to add value to this process and, in fact, would be in conflict with the state’s goal of “Communities and regions are accountable for improving the health of their communities, reducing avoidable health gaps among different cultural groups and managing health care and service resources.”

I appreciate the opportunity to offer comments.

Jan Kaplan, MSW
Director
Curry County Health & Human Services Department



George Rhodes, County Commissioner

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March 4, 2011

The Honorable Governor John Kitzhaber
900 Court St NE
Salem, OR 97301

Honorable Governor Kitzhaber,

Thank you for the opportunity to provide feedback regarding the Health System Transformation Team (HSTT). The goals of the Transformation Team are consistent with the direction that we have taken in Curry County. We have established a vibrant collaborative partnership between Curry County Health & Human Services and the Curry Health District. As the mental health and public health authority, the Curry County Board of Commissioners is exploring further opportunities to partner with the Curry Health District's hospital and clinics, including the possibility of merger.

The Legislative Concept Draft Proposal outlines the responsibilities of newly formed accountable care organizations (ACOs) to provide "integrated physical health, dental, mental health, chemical dependency, home and community based, and long term care and support services." As the local authority, we are uniquely positioned to develop and implement an accountable system in Curry County, but are dismayed at the prospect of a state-imposed ACO without local accountability. During the past year, two state imposed fully capitated health plans were established in Curry County. The most significant impact, particularly from the southern FCHP, has been delays in cash flow to providers which, in turn, have reduced services. This is in stark contrast to the relationship we have with Jefferson Behavioral Health (Mental Health Organization) where payment is prospective, accountability is shared, and we are jointly at risk for costs of psychiatric hospitalization, children's psychiatric residential treatment, and adult psychiatric long term care. I strongly fear that if a new system design does not adequately incorporate the significant triple aim successes already attained by our mental health and public health authorities, these successes could be dismantled.

Additionally, county mental health and public health currently are integral to the public safety infrastructure in our communities through civil commitment processes, jail health, mental health court, PSRB, probation supervision and 24/7 psychiatric crisis response. Potential "health" system transformation could place all of these public safety

March 4, 2011
Hon. Governor John Kitzhaber

collaborations in jeopardy since they are currently supported by braided funding including direct state funding and Oregon Health Plan funds.

As the current local mental and public health authorities, I feel it is imperative that County Commissioners have the opportunity to take a more active role in the formation of Request for Proposals (RFP) and the design of the ACOs. Commissioners are the elected officials that are closest to the patients and their families. As Commissioners, we oversee not only local mental health and public health, but public safety and local social service efforts, as well. Commissioners have broad multi-system oversight and accountability.

The discussions being held at the Health System Transformation Team will lead to changes in the health delivery system which, in turn, will lead to changes in the broader fabric of our communities. System transformation without broad perspective has the potential for costly, inhumane and serious unintended consequences for our communities. It is therefore important that Commissioners have the opportunity to contribute to the discussion on the RFP and the structure of the ACOs. Commissioners should be invited to the table or be offered some way of contributing directly to the decisions affecting the systems for which they are held accountable.

Thank you for your consideration

Sincerely,

George Rhodes, Chair
Curry County Board of Commissioners

CC: Tina Edlund

From: "Bob Dannenhoffer MD" <rdannenhoffer@dcipa.com>
To: "'Tina D EDLUND'" <tina.d.edlund@state.or.us>
Date: 3/7/2011 2:44 PM
Subject: RE: Health System Transformation Team Agenda 3-9-11

Please include these as my comments on the legislative proposal:

1. The entire legislative concept is so very vague. I object to any legislative concept that is so vague as to give inordinate discretion to the rule making process- for example, as written, this legislative concept would give almost total discretion to the rule making process and would allow for the use of current contractors, a state-wide single RFP for a big insurer, small county sized ACO's and almost everything in between.

2. While accountable care organizations are described in many parts of the legislative concept, the definition is weak and does not include the risk bearing that is inherent on these groups. As ACO's are not well defined anywhere, the definitions should be clear so that we can all understand what we're talking about. I think that there is going to be a federal Medicare of definition of ACO's and consultant's views of ACO's that are quite different from what Oregon is talking about.

3. With the focus on single capitated payment for all services, I am uncertain how patients with a primary medical insurance would be handled. For example, about 10% of kids eligible for OHP have health insurance through their parents, get secondary medical coverage through an "open card", and then have managed dental and mental health services. How would those patients be addressed under a single capitated payment system?

4. There is nothing to address the actuarial soundness of the single global payment.

Bob

From: Tina D EDLUND [mailto:tina.d.edlund@state.or.us]
Sent: Monday, March 07, 2011 2:09 PM
To: Alissa ROBBINS; Amy FAUVER; Bob Diprete; Bruce GOLDBERG; Jeremy VANDEHEY; John A SWANSON; Karynn FISH; Linda D GRIMMS; Margie Fernando; Mike BONETTO; Sean KOLMER; Suzanne HOFFMAN; Tina C KITCHIN; Tina D EDLUND
Cc: Amanda SUTTON; Bobbi DOAN; Carolyn WILSON; Diana WOODS;

From: "Mark Webb" <webbm@grantcounty-or.gov>
To: "'tina.d.edlund@state.or.us'" <tina.d.edlund@state.or.us>
CC: "'Gina Nikkel'" <gnikkel@aocweb.org>, "'Andrew Smith'" <asmith@aocweb.or...>
Date: 3/7/2011 12:09 PM
Subject: accountable care organizations: the legislative concept

To: Governor Kitzhaber

RE: Accountable Care Organizations, as articulated in "Preliminary Synopsis for Discussion Purposes", submitted by the Health Systems Transformation Team

Dear Governor Kitzhaber,

I am the Grant County Judge, speaking on behalf of the Grant County Court. I am also a board member of Greater Oregon Behavioral Health, Inc. (GOBHI), a mental health Managed Care Organization, and Community Counseling Solutions (CCS), a private non-profit mental health care provider that provides mental health services in Grant County and three other rural counties.

Accountable Care Organizations, as articulated in the above synopsis, is certainly well motivated and worth considering as one way of addressing health care costs and quality. However, as articulated therein, I have several concerns with the proposed system wide change.

GOBHI has invested at least 15 years in systems development in rural counties. This has involved identifying mental health needs and developing area capacity to meet these needs in rural areas. In particular, it has involved developing the right kind of partnerships that take a long time to mature. For example, we are in the process of building and operating an Acute Care Facility for mentally ill individuals who are a danger to themselves or others. This facility is the fruit of a strong partnership built with Blue Mountain Hospital over time and will serve eastern Oregon rural counties. The synopsis, if implemented in its current form, will likely compromise if not completely undo our efforts in these regards given the kind of novel and untested approach it is taking, and requires.

Our effort has also involved informing and implementing policy changes at

the state level so as to more closely align financial incentives with good clinical outcomes in a responsible, cost effective and quality enhancing way. The synopsis talks as if it will increase the quality of health care while reducing its costs. But there is little reason to believe that it will do this based on the very general programmatic approach described therein.

So, four questions: (1) What evidence does the state have that this approach, if implemented, will in fact improve health care service and reduce its costs? (2) What evidence does the state have that this approach will work equally well across various regions-large and small, urban and rural, counties? (3) What evidence does the state have that this approach will maintain or improve upon, rather than compromise if not undo, the kind of partnerships that are required for successfully implementing the right kind of broad based health care? (4) What evidence can the state provide that this approach does in fact correctly align financial incentives with the right kind of clinical outcomes? I would appreciate receiving answers to these questions. Moreover, if the evidence is not good or compelling, I would urge you to delay implementing this approach in its current form.

Generally speaking, we need the state to approach this matter by identifying the right kinds of outcomes needed or desired, incentivize meeting these in the right sorts of ways, and provide the latitude needed to meet them that is sensitive to the variety of regional challenges, stakeholders and players involved. That is only starting to happen in the current system. More importantly, the synopsis does not appear target these very general goals in the right sort of way. Nor does it appear to respect the local character and authority and role county governments traditionally have played in health care, and should continue to play.

Sincerely,
Mark R. Webb
Grant County Judge



March 7, 2011

The Honorable John Kitzhaber
900 Court St NE
Salem, OR 97301

Dear Governor Kitzhaber,

We appreciate the opportunity to provide feedback regarding the Health System Transformation Team. The Association of Oregon Counties (AOC) strongly supports the Triple Part Aim goals of Better Care, Better Health and Lower Cost. We especially appreciate the discussion that has been focused on the local provision of physical and mental health care. It is with these needs in mind that we would like to comment on the process and make suggestions for the legislative concept of the Medicaid system redesign and the ensuing Request for Proposals (RFP) for Accountable Care Organizations (ACO).

Any list of fundamental elements for Accountable Health and Long-Term Care Services must include a working partnership with the local public and mental health authorities if they are to be successful in integrating the services, supports and potential health intervention points in a population-based manner. County Commissioners are, by statute, the mental and public health authorities.

Additionally, Commissioners are the elected officials who are closest to the patients, and the public holds us accountable for these services. Millions of county general fund dollars are spent annually to help support and improve community mental health and public health services. County Commissions are an integral part of the system and are in partnership with the State in this effort.

The discussions being held by the Health System Transformation Team will lead to changes in the delivery system of which we are a crucial part. As the State's local partners in providing these services, it is critical to the ultimate success of the Transformation process that Commissioners have the opportunity to contribute to the discussion on the RFP and the structure of the ACOs.

The intent of this letter is to request that a County Commissioner be invited to the table or that our Association be offered some meaningful way of contributing directly to the decisions affecting the system for which we are held accountable.

We are open to discussing this further at your convenience.

Sincerely,

A handwritten signature in black ink that reads "Bill Hall".

Commissioner Bill Hall
Lincoln County

A handwritten signature in black ink that reads "Kathy George".

Commissioner Kathy George
Yamhill County

Co-Chairs of the Human Services Steering Committee

From: "Joe Robertson" <robertjo@ohsu.edu>
To: "'Tina D EDLUND'" <tina.d.edlund@state.or.us>
CC: "'Bruce GOLDBERG'" <bruce.goldberg@state.or.us>, "'Mike.Bonetto@state.or...'
Date: 3/7/2011 4:36 PM
Subject: Legislative Concept Paper comments

Tina:

Here are some initial observations from the legislative concept paper distributed on March 2nd:

1. The use of local integrated systems in regions makes a lot of sense. At some point the model creates incentives for development of specialty services that will add costs to the total system unless regional ACO's are required or strongly incentivized to refer to centers with adequate volume and existing delivery platforms. Duplication must be reduced to save costs at a society level. Can we imagine regional Children's' Hospitals? I hope not.
2. The paper defines the applicable universe to "existing eligible's". This continues to leave lives outside the system and thus the pressure of cost shifting, and unequal playing field for providers. As budgets are tighter, the historical pressure to exclude eligible's could threaten effectiveness.
3. Patient centered homes and "integration" are assumed to generate value. There is little in defining the concepts as it assumed global budgets will create the proper incentives. There may need to be less prescription on structure and more on outcome.
4. For most parts of the state the model can work since there is usually a singular provider and thus a global budget can be useful. In Portland/Vancouver the multi provider nature of the market makes the administration more complicated.
5. Many references to evidenced based medicine. Need to put definition to it and then tie to tort reform.
6. How do you speak to the value of integration vs. the leverage of a more concentrated market? Maintaining consumer choice will need to be addressed somehow.
7. The model assumes expanded service at current support levels through reallocation of existing resources. The challenge is with the portion of the system that has resources allocated away – take a high-demand condition such as heart disease – will have to constrict and develop "rationing" methods acceptable to society. Is the market acting enough? If chronic care savings is the long run answer, what do you do with heart disease still in place for decades until you change behaviors?

From: "Charles Kilo" <kilo@ohsu.edu>
To: "Bruce GOLDBERG" <bruce.goldberg@state.or.us>, "Mike BONETTO" <mike.bone...>
CC: "yolanda.baca@providence.org" <yolanda.baca@providence.org>, "melinda.ba...>
Date: 3/7/2011 11:06 AM
Subject: RE: ACTION: Health System Transformation Team

Copying Bruce, Mike and Tina on this...

I have questions about this legislation, and believe that there is information deal behind the scenes in terms of overall direction, that is not made clear in the legislation but would perhaps alter the way one might assess it.

A short list of questions:

1. I cannot tell how this legislation would impact, affect, or be affected by Oregon's federal waiver application. I would hate for the state to pass legislation if only to need additional legislation once we received a waiver. The sequencing of those objectives should be made clear in non-legislative documents.
2. I am in favor of accountability and it is clearly alluded to in the legislation, but in ways that feel vague. "Population accountability" might be defined/clarified. It is much easier to conceptualize in smaller communities with one hospital than it is in urban areas.
3. We must realize that the US mindset seems to want to jump from one solution to the next in healthcare. Our industry has done that many times just in the past decade. Recall that RHIOs there THE solution for about 12-18 months (~'04-05) with each state pouring a few million dollars into them, only to see almost all of it evaporate shortly down the road when the next new thing came along. There have been other times in the past decade where IT was presented as the key solution. In each situation, the "solution" was taken out of context of the larger system, felt to be more potent than it was,

and decisions were made that were not congruent either with the evidence-base or actual experience. My sense is that some aspects of ACO's might be falling prey to this tendency. For instance, what does integration mean – the word is used repeatedly in the document, but there is no explicit definition. My former practice, GreenField Health, was highly integrated even though independent, perhaps more integrated functionally than many in “integrated systems”. Does integration mean literal integration, virtual (functional) integration, etc?

4. Point #3, has substantial implications for independent practices obviously. I do not believe that there is an evidence-base that suggests that integrated systems perform better than independent but highly virtually integrated practices. This is particularly true of Oregon's best primary care groups.

5. #3 & 4 suggest that we should be driving toward outcomes as the objective, not driving toward a structure assuming that the structure will produce a certain outcome. That logic has failed repeatedly in healthcare over the years unless there is a strong evidence-base for the structure... which is not present in this case apropos to point #4.

- Chuck

Charles M. Kilo, MD, MPH
[cid:image001.gif@01CBDCB4.8521CD00]
Chief Medical Officer | OHSU Healthcare | Oregon Health & Science
University (OHSU)
3181 SW Sam Jackson Park Road, CR9-6 | Portland, OR 97239 |
kilo@ohsu.edu<mailto:kilo@ohsu.edu>
Assistant: Connie Straub | 503-494-0388 |
straub@ohsu.edu<mailto:straubc@ohsu.edu>

From: Robin Minto [mailto:rminto@orbusinesscouncil.org]
Sent: Friday, March 04, 2011 9:17 AM
To: jcleven@tpcllp.com; majd.el-azma@lifewisehealth.com;
Chris.D.Ellertson@healthnet.com; fordd@careoregon.org;

March 7, 2011

Tina Edlund
Deputy Director for Planning and Policy Implementation
Oregon Health Authority



Dear Ms. Edlund,

I have reviewed the Legislative Concept for the Health Systems Transformation Team that was distributed on March 2, 2011, and appreciate the opportunity to provide comments to the team.

Lane County Health & Human Services has a keen interest in the work of the transformation team, since we are engaged in community health on a number of levels—Lane County is the Public Health and Mental Health Authority charged with monitoring and improving community health in our area, we also operate LaneCare (a Managed Mental Health Organization), and we operate the Community Health Centers of Lane County (a Federally Qualified Health Center providing primary care, mental health, prenatal, and dental services). I understand the system is a complex one, and fully support the articulated triple aim: improving the health of Oregonians, increasing quality and reliability of care, and reducing the costs of care.

In reading the draft legislative concept, I have some concerns.

First, the draft concept seems to ignore the role of County governments as the Public Health and Mental Health Authorities. The County is a key partner of the state in achieving the first goal of this draft—improving the health of Oregonians. The local Health Authorities provide local residents easy access to policy makers, and through public comment and local community engagement efforts, provide regular opportunities for the public to influence health priorities and programs. And, in fact, to hold government accountable for outcomes at a level that is most accessible to them.

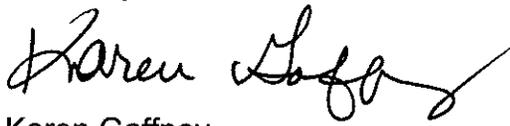
In addition to access and accountability for the public, the impacts of any failures in the health care system are also felt locally. Lane County created LaneCare to manage the mental health OHP benefit 13 years ago, largely because of the impact that **poorly** managed mental health services would have locally—this includes impacts on the jail and public safety partners, on basic needs and social service partners, on the schools, on hospitals, and others. Lane County has strong relationships with these local partners, and continues to work well to provide good access to care, to fund prevention and early intervention strategies, and to make strategic investments in the delivery system. And, Lane County currently allocates significant County resources to support community mental health and public health services.

My second concern is the underlying premise that by combining the funding for physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and supports, the result will be improved

outcomes for the health of individuals, and the quality and cost of health care. The proposal as written ignores many of the strengths in the current system that might actually serve as supports for creating better health at a lower cost in the community. Where those systems are currently strong (such as Lane County) forcing those funds through a new single entity might actually do more harm than good. Where there are currently strong natural communities of care, they should serve as building blocks for the transformation the state is seeking. The integration of care and improvement in services will come through changes at the service delivery level—not as a result of changing the entity through which the funds flow.

Thank you again for providing the opportunity to comment on the draft.

Sincerely,

A handwritten signature in black ink, appearing to read "Karen Gaffney". The signature is fluid and cursive, with a long, sweeping tail that extends to the right.

Karen Gaffney
Acting Director
Health and Human Services

Proposed Additions to Legislative Concept

414.018 Goals; Findings - Section 3

Insert (g) Savings are realized and people stay healthier when they are educated to become better decision-making consumers of health care and active in prevention behaviors before they become patients.

Insert (h) Improved patient safety results in healthier people and reduced costs especially when avoidable care facility transmitted infections and other preventable errors are reduced.

Insert (i) Health is improved and cost reductions realized when care recipients become active responsible partners in their care and not passive recipients of care.

Insert (j) Health care outcomes are enhanced when patients have competent advocate-system navigators and other health education professionals such as community health workers.

Insert (k) People have a right and responsibility to enact end of life directives before they are needed.

414.610 Legislative intent

Insert (6) People have a right to retain their primary care providers of choice over time regardless of which health insurance plan they choose.

Insert (7) To address the rapidly expanding need for primary care providers especially in rural areas, the definition of primary care provider will be expanded to include a wider range of qualified, licensed professional providers.

Insert (8) Where ever regulations, coverage and/or related issues affecting care recipients are being discussed or decided, recipients will be present.

414.025 Definitions

Section 5 (f) Insert – remedial or [preventive, complimentary, holistic or wellness] care . . .

Section 5 (p) insert – any other medical [and complementary, holistic] care . . . remedial [preventive, wellness]

414.725 Accountable care organizations

Section 7 Insert (c) When there is a medical error, prompt explanation, apology and equitable restitution will occur. The organization will conduct an adverse event analysis and quickly incorporate recommendations and policy changes into daily practice management.

New Statute – ESSENTIAL ELEMENTS ORS 414.xxx

Section 4 Insert (e) Patient Advocate-System Navigators will be provided effectiveness training and compensation to attend necessary meetings and consultation visits.

Section (5) line 1 insert individuals [quality of care as well as quality of caring] including . . .

Submitted by Charles B. Maclean, PhD, advocate@philanthropynow.com 503.297.1490 Version 1.3 3/7/11

This input drawn from personal experience as a care recipient-partner; review of health care literature; interviews with patients and health care leaders; national meetings of patient advocates and complementary care providers and training as a medical educator.

Draft: March 7, 2011

To: Mike Bonetto, Health Care Advisor to Governor John Kitzhaber

From: Martin Taylor, Director of Health Policy and Member Centricity

Re: Feedback on Transformation; Legislative Concept Preliminary for Discussion Purposes.

The (LC draft look-alike) distributed Wednesday March 2, 2011 offers tremendous potential to frame the discussion around Health Care Transformation the correct way to have success in the next 17 weeks.

The following comments are not a reflection of CareOregon needs or positions. This is advice and is intended only for design consideration and to help you navigate the politics in hope reaching a successful conclusion.

Three Missing Components of a Plan: Geography, Governance and Timeline.

Without guidance on the following components the current systems are likely to respond by conforming themselves with new conditions and not actually transforming into something new.

Geography:

The natural approach to creating an ACO and responding to an RFP is to take current political regions and contracts and try to modify the approach. Counties are hosting meetings. MCO's are discussing who will contract in each county. This is a natural association and frankly reflects current provider networks and service areas.

The Triple Aim's approach to population health is based on "communities of interest". Another more organic view of health delivery is service areas such as the Dartmouth Atlas Hospital Service Regions.

Advice: To move from the current state to a different regional approach will need to be spelled out in some way. This doesn't need to be proscriptive. The Legislative Concept could describe an RFP that would be awarded to proposals that describe their geography based on communities or service areas.

Governance:

Groups are meeting to discuss how to create alliances for proposals that look like the ACO concepts. It should come as no surprise that there are a number of competing constructs and conveners. Is this a County lead effort? Or a hospital lead effort? Or a plan lead effort? Or an industry leaders OHLC effort? Or a consumer lead effort?

While it is possible to imagine value in a period of competition where the best ideas and actors emerge from the pack there is also a risk to a process that lacks clarity about which actors need to be convened. Do we really want any of these elements of the health system disproportionately represented in a successor system? How do we create community based solutions where the community is left out of initial concepts and to respond to initiatives taken by industry stakeholders? Is it transformation when the existing systems reorganizes and modifies itself but doesn't actually become something new or different?

Advice: To move from the current system requires an Legislative Concept that is explicit about who needs to participate in the drafting of an RFP and that list needs to include relevant provider networks along with representatives from the consumers, community social services, local government and public health.

Timeline:

It is true that requiring this much change too quickly isn't realistic. It is probably also true that a 16-19% rate cut will cause some parts of Oregon to face the problem of too little essential health care provider infrastructure remaining in-tact to complete an RFP in twelve months.

Advice (3 parts):

- 1) Open your RFP timeline by September 2011. *Accept proposals as they come in.* Close RFP's by July 2012.
- 2) Create a *"Transformation Fund"* that allows you to infuse resources into a region/ACO upon having successfully received a contract via the RFP. This pays for some of the costs of transformation. It also creates an incentive to moving quickly. It may also be seen as a life-line for those looking to possibly leave Medicaid.
- 3) *Phased Build* with 2014 as the real completion date. The first round of RFPs are likely to cherry pick geography that has fewer provider access challenges. There will be "grey areas". July 2011 to July 2012 has the purpose of creating your ACO partners. Each year you push these partners to help solve additional state problems including how to cover the grey areas. Have a bar for the RFP's in 2011 that is realistic but do telecast that the bar will go up each year and reach your ideal by 2014.

Ostrom's eight principles.

Moving to a global budget with a single regional integrating entity creates a perfect opportunity to consider a "Commons" approach. Without using the language of the "Health Commons" Elinor Ostrom's principles could be built into the legislative concept.

"Individuals know the boundaries and limits of the Common Resource." - **Transparency**

"Rules are locally made and adapted to context." - **Regionalism**

"Decisions are made together." – **Equity in Governance**

"Measurement and monitoring are inherent and active." - **Accountability**

"Effective sanctions are agreed upon." - **Enforcement**

"Mechanisms for conflict resolution are in place." – **Dispute Resolution**

"Latitude from higher authorities support local decision making" – **Flexibility & Innovation**

"Communities are empowered at multiple levels through inter-independent "nested" commons – **Empowered Communities**

The current Legislative Concept really does a wonderful job setting a context that would support most of these principles. A few could be better spelled out: Transparency, Equity in Governance, Dispute Resolution.

To: Tina Edlund, Deputy Director of Policy and Planning Implementation
Oregon Health Authority

From: Karl Brimmer, Mental Health and Addictions Director, Multnomah County
Kim Burgess, Human Services Division Manager, Washington County
Cindy Becker, Health, Human Services and Housing Director, Clackamas
County

CC: Bruce Goldberg, Co-Chair, Health Systems Transformation Team
Mike Bonetto, Co-Chair, Health Systems Transformation Team
Health Systems Transformation Team Members
Commissioner Janet Carlson, President, Association of Oregon Counties
Morgan Cowling, Executive Director, Coalition of Local Health Officials
Gina Nikkel, Executive Director, Association of Oregon Community Mental
Health Programs

Date: March 7, 2011

Re: Proposed Additions to the Health Systems Transformation Team's
Legislative Concept, Delivery System Changes

We appreciate the opportunity to comment on the Health Systems Transformation Team's proposed legislative concept. Clearly, a great deal of thought has gone into developing this concept.

Given county responsibility for public safety, public health, mental health and the ancillary services necessary to provide the support people need, the tri-counties are proposing the following addition to the language in the Discussion Draft—Part 2, Delivery System Changes. After the first sentence in 414.725 (c), please insert:

The applicants will be required to establish a formalized relationship with local mental health authorities and local public health authorities which consists of coordination and significant influence in decision making. Applicants are required to get approval of the county authorities in each county where they intend to provide services.

Thank you for your thoughtful consideration of our recommendation. If it would be helpful, we would be happy to provide additional information to support our request.

From: "Bob & Gina" <bgnikkel@gmail.com>
To: "Tina Edlund" <tina.d.edlund@state.or.us>
Date: 3/6/2011 8:58 PM
Subject: Prevention of Mental Disorders, Substance Abuse, and
ProblemBehaviors: A Developmental Perspective -- Beardslee et al. 62 (3):
247-- Psychiatr Serv

Much of the work for preventing mental health disorders falls outside the usual domain of health and even mental health care. This represents part of my concern abt the narrowness of thinking abt how to manage health care risks.

<http://psychservices.psychiatryonline.org/cgi/content/abstract/62/3/247>

Bob Nikkel



March 7, 2011

The Honorable John Kitzhaber
900 Court St NE
Salem, OR 97301

Dear Governor Kitzhaber:

Thank you for opportunity to provide feedback regarding the Health System Transformation Team 's legislative concept. The Association of Oregon Counties supports the team's goals and discussions on local provision of physical and mental health care. Since counties serve as the mental health and public health authorities, any issue surrounding provision of mental and public health services are of great importance to us.

The legislative concept as recently proposed outlines responsibilities of newly formed accountable care organizations that will provide "integrated physical health, dental, mental health, chemical dependency, home and community based, and long term care and support services." Additionally, an "essential element" of these accountable care organizations is to "work cooperatively with community partners to address public health issues."

In our role as mental health and public health authorities, it is imperative that county commissioners be involved in taking a more active role that would, at a minimum, include forming Requests for Proposals and designing accountable care organizations. Additionally, as elected officials who are closest to our constituents who experience mental and physical illness, we are held accountable by the public for these services. Millions of dollars in county general funds are appropriated annually to support community mental health and public health services. County governance is an integral part of the mental health and public health systems.

Discussions being held by the Health System Transformation Team will lead to delivery system changes that could significantly impact our county residents. It is crucial that county commissioners contribute directly to decisions affecting the system for which we are held accountable.

We appreciate your consideration and look forward to discussing these issues further with you and your policy representatives.

Sincerely,

A handwritten signature in blue ink, appearing to read "Janet Carlson".

President Janet Carlson
Marion County

A handwritten signature in blue ink, appearing to read "Tammy Baney".

First Vice President Tammy Baney
Deschutes County

From: "Vern Saboe" <vsaboe@comcast.net>
To: "Tina D EDLUND" <tina.d.edlund@state.or.us>
Date: 3/4/2011 8:11 AM
Subject: Re: Health System Transformation Team FOLLOW UP

Hi Tina,

Recommendation: Part 4, page 1 414.025 (5), insert in after (f) "No health plan or insurer may discriminate against any health provider acting within the scope of that provider's license or certification."

This is consistent with new federal statutory law in the Affordable Care Act, Section 2706. I am unclear if indeed this is where this language should be inserted but in our opinion it is indeed appropriate as Oregon law cannot conflict with federal statute.

Thanks,

Vern Saboe
Oregon Chiropractic Association
541-231-4528 cell

----- Original Message -----

From: Tina D EDLUND

Cc: Alissa ROBBINS ; Amanda SUTTON ; Amy FAUVER ; Bob Diprete ; Bobbi DOAN ; Bruce GOLDBERG ; Carolyn WILSON ; dbianco@comcast.net ; Diana WOODS ; Jeremy VANDEHEY ; John A SWANSON ; Judy MORROW ; Julie EARNEST ; Karynn FISH ; Kathryn L MIKESELL ; Katie L SMITH ; Linda D GRIMMS ; Margie Fernando ; Mike BONETTO ; Richelle BORDEN ; Sean KOLMER ; Suzanne HOFFMAN ; Tina C KITCHIN ; Tina D EDLUND

Sent: Thursday, March 03, 2011 12:00 PM

Subject: Health System Transformation Team FOLLOW UP

Team Members,

I'm attaching the legislative concept language from last night as a separate document for your review and comment.

We are looking for specific and substantive feedback to the framework and language for delivery system transformation as it's envisioned in this concept. If there are areas that need additional clarification or elaboration, please let us know that as well. It will be a great help if you reference which part (1-4) and section your comments are directed toward.

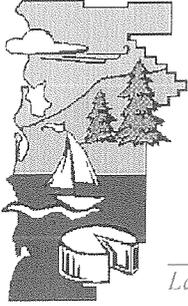
We will accept comments up until noon on Tuesday, but I would ask that everyone have something to me by the close of business on Monday, March 7th if at all possible.

This will be our main topic for discussion at our meeting on the 9th. I look forward to your comments.

Thanks,
Tina

Tina Edlund
Deputy Director for Planning and Policy Implementation
Oregon Health Authority
(503) 781-7179
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Tillamook County



Land of Cheese, Trees and Ocean Breeze

Charles J. Hurliman
County Commissioner
201 Laurel Avenue
Tillamook, Oregon 97141
Phone 503-842-3403
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TTY Oregon Relay Service

March 7, 2011

Governor John Kitzhaber
900 Court St NE
Salem OR 97301

RE: Health System Transformation (HSTT)

Governor Kitzhaber;

Thank you for opportunity to provide feedback regarding the Health System Transformation Team (HSTT). The Association of Oregon Counties supports the goals of the Transformation Team and the discussion on the local provision of physical and mental health care. As the mental health and public health authority, any issue surrounding the provision of mental and public health services are of great concern to me as a County Commissioner here in Tillamook County.

The Legislative Concept Draft Proposal outlines the responsibilities of newly formed accountable care organizations (ACOs) to provide "integrated physical health, dental, mental health, chemical dependency, home and community based, and long term care and support services." Additionally, an "essential element" of ACOs is to "work cooperatively with community partners to address public health issues."

As the current mental health and public health authorities, I feel it is imperative that County Commissioners have the opportunity to take a more active role in the formation of Request for Proposals (RFP) and the design of the ACOs. Additionally, Commissioners are the elected officials that are closest to the patients and the public holds us accountable for these services. Millions of county general funds statewide are used annually to support the community mental health and public health services.

The discussions being held at the Health System Transformation Team will lead to significant changes in the delivery system of health care in Oregon. It is important that the Commissioners have the opportunity to contribute to the discussion on the RFP and the structure of the ACOs. A Commissioner should be invited to the table or be offered some way of contributing directly to the decisions affecting the system for which we are held accountable.

Governor John Kitzhaber
March 7, 2011
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We are open to discussing this further at your convenience.

Sincerely,

A handwritten signature in cursive script, appearing to read "Charles J. Hurliman". The signature is written in dark ink and is positioned above the printed name.

Charles J. Hurliman
Tillamook County Commissioner

To: Tina Edlund, Deputy Director of Policy and Planning Implementation
Oregon Health Authority

From: Kim Burgess, Human Services Division Manager, Washington County
Kathleen O’Leary, Public Health Administrator, Washington County; Chair, Conference
of Local Health Officials

CC: Bruce Goldberg, Co-Chair, Health Systems Transformation Team
Mike Bonetto, Co-Chair, Health Systems Transformation Team
Health Systems Transformation Team Members
Commissioner Janet Carlson, President, Association of Oregon Counties
Morgan Cowling, Executive Director, Coalition of Local Health Officials
Gina Nikkel, Executive Director, Association of Oregon Community Mental Health
Programs

Date: March 7, 2011

Re: Proposed Additions to the Health Systems Transformation Team’s Legislative Concept,
Delivery System Changes

We would like to offer further comment on the memo forwarded from the Mental Health Authority leadership of Washington, Multnomah and Clackamas Counties forwarded to you today.

Washington County strongly endorses the language addition proposed in the memo:

The applicants will be required to establish a formalized relationship with local mental health authorities and local public health authorities which consists of coordination and significant influence in decision making. Applicants are required to get approval of the county authorities in each county where they intend to provide services.

This recommendation does *not* come from a belief that things should stay the same, or desire to obstruct change. In fact, it is **motivated by our strong commitment to assist in the efforts to achieve Triple Aim goals and our belief that counties have critical assets that can be used within integrated care organizations to achieve those goals.**

Accountable Care Organizations’ success in achieving triple aim goals will require organizing care, social services, supports and potential health intervention points in a population-based manner. Accountability must extend to a population, not simply “members” of an Accountable Care Organization. Counties have the ability and expertise to bring human services, housing, coordination with local criminal justice, and the population-based expertise to improve the health of the community.

In public health specifically, teen pregnancy reduction, vaccine preventable disease interventions, and case management supports are examples of Medicaid enabled services provided by a continuum of lower cost providers that includes nurse practitioners, nurses and community health workers.

To be effective, critical connections to local community interests must be preserved in a redesigned system: the well-established relationships with local law enforcement, community corrections, service districts, school districts, housing departments, and others which are central to the county public and mental health authority roles.

Local government is responsible for much of the safety net, including responsibility for public safety including jails and community corrections, local human service systems, and public health. These systems are significantly impacted by the decisions of any potential care organization managing OHP lives. Cost shifts must reliably not occur and counties need assurance that this will be the case.

The majority of community-based public and mental health services are currently funded with Medicaid. The responsibility for uninsured, communicable disease, and other overarching responsibilities embedded in the statutory role of Public and Mental Health Authority, will continue into the future. Few resources will remain subsequent to this redesign to assist with these continued responsibilities.

County Community Health Programs and the Oregon Health Plan Mental Health Organizations (MHO's) have specific expertise in the management of complex systems of care to the most vulnerable and challenging citizens with severe mental health and chemical dependency disorders not available anywhere else in the health care system. Examples include successful programs such as Children's Intensive Services, Wraparound, and the Adult Mental Health Initiative. This expertise needs to be preserved and incorporated into the integrated delivery system.

Thank you for the opportunity to comment and your thoughtful consideration of our recommendation.

From: "Joe Anderson" <cjoe.anderson@gmail.com>
To: "OHPB.Info@state.or.us" <OHPB.Info@state.or.us>
Date: 3/5/2011 9:09 AM
Subject: Health System Transformation Team LC

The document is difficult to read and understand. It seems redundant in many places. Because of this I am unable to make any recommendations.

C. Joe Anderson

From: "Nick Benton" <nick.benton@corvallis-clinic.com>
To: <OHPB.Info@state.or.us>
Date: 3/7/2011 8:30 AM
Subject: Health System Transformation Team LC

To Whom it Concerns,

As a member of the OMA I was asked to consider the draft legislation for state healthcare reform. I'm a data guy so I'm going to give it to you short and sweet.

Prevention is great and it gives people more quality years of life. I'm all for it, but there is one big problem. Prevention requires the patient to actually make life changes. You can be the best doctor in the world, but if your patients don't eat less, drink less, stop smoking, start exercising etc.. You aren't getting anywhere. There has to be strict guidelines about what you "won't do" for patients who are non-compliant. Example: A primary care doctor tells his patient that he is fat and diabetic, and if he doesn't loose weight and exercise, then we aren't going to be spending money on all of his diabetic complications. We will make him comfortable and then just let him die. How many patients didn't make a life change because we enable them, and reassure them that we will spend whatever it takes to fix any fall-out from their addiction. Nuff said on that point.

According to the Kaiser Family Foundation (arguably the best source of information on this topic, and see, kff.org/insurance/7670/cfm) all of this preventive care, and prevention of mistakes and duplication of tests and services, are a good idea; however it will not save money in the "long run." They are short term savings only. That is because they have concluded, after exhaustive research, that the driver of healthcare inflation is most directly caused by "New and expensive (patented and proprietary) drugs and treatments." Think about it. What is expensive and inflationary. It's that new \$93,000 prostate cancer drug that keeps him alive for another 4 months (Provenge). Yes, Medicare and Medicaid pay for this stuff.

They conclude you will never control healthcare inflation for the long run, until you delay or prevent the implementation of new drugs and medical technologies. We wouldn't be spending 17.5% of our GDP on

healthcare in America right now, if we had 10 or 20 year old technology/drugs. And if you ask a doctor who practiced 10 or 20 years ago, he will tell you that we did a pretty good job with what we had too.

Since politicians can't seem to say "no" to expensive new drugs and technologies, I have a suggestion. Attack the patents. Patents are what allows a drug company to charge a 1000% markup from generic, for a new kind of tetracycline for acne. Patents are what allows an implant maker to charge \$30,000 on average, for the plates and screws that go into a low back fusion, even though we have been using plates and screws for back fusions for at least 50 years.

So how do you attack patents? Ask a patent lawyer. It's done all the time. I won't bore you with the details except to say that it can be done, and done well, but mostly because these patents for marginal improvements in existing technologies, never deserved a patent in the first place, because they really didn't meet the basic requirements of being "novel and useful." Also, they aren't sold in a free market, which is implied in the constitutional right to a patent.

If you want more detail about the patent issue, search my name on the internet news letter TheLundReport.org. I wrote a series of articles on this strategy. Also, TheLundReport.org is a very good source of information about healthcare policy and politics specific to Oregon.

Sincerely,

Nick C. Benton, MD
The Corvallis Clinic PC
Corvallis, Oregon
OMA Member (for many years)

From: "Tom Eversole" <eversole.tom@gmail.com>
To: <ohpb.info@state.or.us>
CC: <tina.edlund@state.or.us>
Date: 3/4/2011 8:14 PM
Subject: Health Systems Transformation Team

This comment is for consideration by the Health Systems Transformation Team.

Given the anticipated 20% reduction in Medicaid investment discussed at the March 2 Health Systems Transformation Team meeting, the proposed legislation should include a provision to direct utilization of a portion of Medicaid benefits through Oregon's Federally Qualified Health Centers. FQHCs realize a nearly full-cost reimbursement for Medicaid encounters (including Dental and Mental Health.) Any revenues above expenses generated at FQHCs must be directed to increasing access to care and/or quality improvement. FQHCs are integrated health care homes.

The March 2 discussion predicted dire times ahead, and more Oregonians will find themselves without health care while "on our watch." This legislation would not be without controversy, but such times call for bold, innovative and decisive action.

. The Medicaid and self pay (uninsured) patients so served would need to "belong" to the FQHC practice wherever they received their primary care. Increased Medicaid revenues generated through the FQHC "wrap around" payments could be directed to "Affiliation Agreements," which could be used

to contract for providers in currently non-FQHC practices. That would increase access points for Medicaid and uninsured patients in already established practice settings.

. Choice of provider is a value we strive to preserve. However, simply reducing Medicaid will cause the most vulnerable Oregonians to fall out of regular primary care and into emergency departments. If the current trajectory in fact includes losing 20% of Oregon's Medicaid resources versus maintaining or increasing it, why would we not consider such legislation? Sadly, for someone whose choice we are predicting will become care vs. no care, a choice about provider A vs. provider B becomes relatively less concerning.

Thank you for considering this idea. Thank you for your work on these difficult and important problems.

Tom Eversole

From: "Joe Hassett MD" <joe.hassett.md@aaimcare.net>
To: <OHPB.Info@state.or.us>
CC: <OMA@theOMA.org>, "Joe Hassett MD"
<joe.hassett.md@aaimcare.net>
Date: 3/7/2011 11:08 AM
Subject: Health System Transformation Team LC - public comment by JH

Having been offered the opportunity by Dr. Dannenhoffer and the OMA to make comments to the Health System Transformation Team, I intend to comment on the legislative draft initially with only a few broad points, since there is not enough substance offered in the draft to respond to how things would actually work out. I must admit that many of my comments below are about healthcare reform in Oregon in general, and not a line-by-line response to the draft document. I will do that at a subsequent point, but as in all arguments, focusing on what should be discussed is always part of the debate. I do not assume that the views I express are necessarily the only way forward, but I do believe that the give and take of debate can and often does shine a useful light on the path ahead.

1. It does not foster confidence, that a document and its underlying philosophy will be able to transform into a concrete reality, when it is filled with so many platitudes and vague goals that are not attached to a concrete framework, or even to a suggested path on how to become realized. A good deal of the document sounds like the "spin" of how the state would like things to work out. I think that onlookers at the process of healthcare reform in Oregon might have more confidence in the way forward, if the language describing the legislative concept would simplify, talk in simple declarative sentences, and as much as possible include details and examples.

2. The hard reality to come is how will the state take the citizens whose health it is responsible for, and both cut costs dramatically, improve the quality of care, and do this immediately, with a budget crisis breathing down the state's neck. Phrased that way, It is clear that something will have to give way, and we are all waiting to hear just what the state will compromise on. If one reads the

legislative concept, and one cannot tell, then something is missing - clarity at the very least.

3. I read this draft document as saying that the "Kaiser HMOs" of this world will be given the state's patients' lives to care for, and that the private practice providers in Oregon will be excluded from these patients, presumably because the state wants to, but can only bundle charges when working with large HMOs. The strategy and solution proposed by the draft document implies that the problem the state's healthcare reform is targeting in Oregon is the excesses created by the fee for service system. Skipping the debate on the accuracy of that assessment, I wonder if the state has considered the impact of its plan on all the small business providers who have built their lives and businesses around "the fee for service system". Where is the transition period that is the usual courtesy when government changes the rules of the road?

4. Does the state have any model or proof of concept data that shows that their way can and will be a successful way forward. I don't see it being offered in any public debate. I see only the state proposing what it wants. The reason to radically restructure the system now is that the state has a budget crisis now, and wants to use that reality to force change. Those of us who have spent a lifetime working in health care are now being told by the political class how to revise a major segment of the Oregon economy, and a large emotional part of every citizen's life. Any person experienced in change will know that it is going to take years to modify healthcare. Why can we not make the changes steadily and gradually, with respect for all the elements and concerns involved. I think that way is not being taken because that would be bottom up change, and the state wants to see top down change, and to see immediate change for budgetary reasons. Can the state convince us all that it knows best? It had best be able to do so, because as a collaborator the state shows little ability to forge a consensus. It has typically seemed to me in my personal dealings with OHA, it has been their way or the highway. If providers in Oregon are offered such a choice, will they accept the Oregon vision, or will they refuse the Oregon contract? That will be an interesting dynamic to watch.

5. I personally think that Oregon does not seem to be getting the

significance of the negative vibes the nation showed when Obama made a broad, and to some unsettling, move on healthcare. Now we have Oregon saying "full speed ahead" with reform. It is a case of tin ear with our politicians, if you ask me. My point is that great change is only good change when it is done gradually enough that people are allowed to adjust. The politician who ignores that conventional wisdom will often reap only a counter-revolution.

6. It appears the state wants to use its power to bundle patients, and then "sell" these lives at the lowest possible price to whomever it can get to buy them, and thus have someone else (a large HMO) take the risk that the state does not want to take, because the risk has proven too expensive. Does that not just move the question into the hands of the HMO? Has such a reorganization actually done something to remodel healthcare? Or has it just gotten the state's politicians off the hot spot of responsibility?

7. To create true value in healthcare we need to ensure money is spent to buy something that has lasting value - improved health now and in the future. Treating symptoms, however laudable, is not going to be the frugal way to true reform. Symptoms will always occur, and will always seek treatment. To be pursued by all those who want lasting healthcare reform is to create a path to prevent symptoms.

8. To my mind, healthcare reform should mean going into schools and teaching high school and college classes on managing personal healthcare. Insurances need to offer products that are 100% prevention of illness oriented. If one can go to a safe driving school and get \$ off your car insurance, why can't people complete preventive health programs that result in discounts off sickness & accident insurance. Certainly there are high cost target areas like metabolic syndrome and its consequences that should be target areas for intervention. Why do we want to reduce and constrain health care services for all, so that there will be \$ left over to pay for those who abused their bodies, or aided and abetted their illnesses.

9. Health care reform does not need to change the system, as much as it needs to focus on where we are wasting our money, and learning how to stop doing that. What the state is coming to in healthcare reform is certainly going to be a contraction of services. It certainly appears

like the state wants to funnel as much reduction in dollars via providers, both reducing provider income itself, and constraining the provider's ability and authority to order services that are "unnecessary". But if we finally agree that it is time to say NO to unnecessary services, then why can we not agree on saying NO with clarity and purpose? It makes no sense to me to "starve the provider system" as a way to constrain services. The human capital at stake will be hard to replace, when the winds of the future change direction. Why cannot the state enlist provider organizations to outline services that are consistent with peer reviewed mandates on diagnostic and treatment procedures, and endeavor to establish and apply such a code of services? The answer that I come to is that politicians do not trust providers to be unbiased and capable of separating their recommendations from self-interest.

10. To my mind, however, the reform we need to apply is aggressive case management on those diagnoses and high cost patients where we decide we are wasting money. In such cases we should use evidence based and medically peer reviewed standards of care to bring such outliers into compliance (i.e. reduce their non-essential services). We need to pay for such case management, and shift monies out of fee for service diagnostic and procedures codes into case management codes that would pay for non face-to-face services. All too often reimbursement schemes to providers have been cut, only to find that providers are driven to increase volume when reimbursement is reduced. The state can send the incentive the other way by offering well crafted case management codes. Codes might be created for case management of specific, individual diseases like diabetes or asthma, or created for bundled case management of one-time events like pneumonia or heart attack. If case management codes for individual diseases were offered to either private practice providers or big box providers, then the provider class could and would be fully engaged in preventive care, but now on a disease by disease basis for whichever patients need such case management.

11. The requirement in the draft document to provide comprehensive services by contract seems to be particularly broad, presumably partially to make it logistically possible to bundle as many charges as possible. This requirement seems likely to mean that no new start-up ACO will be able to provide the comprehensive services required without being part of a network that is backed up by a big-box, hospital-based

provider. Thus I am assuming that the draft document envisions that <5 agents will emerge to take the state's contracts. I think these agents already exist, and are centered around our major hospitals. I see this direction as having major negative impact on private practice providers in solo and small group practices, and on specialty driven private practices. And if bundling of services is accompanied by a requirement that all payments go directly to the contracting agent, who then gets to distribute the profits to contracting providers, this direction will effectively make most physicians and providers the employees of the small number of contracting agents. That is certain to bring major and unpredictable change to Oregon's physician class. Who will stay.....who will go out of state.....Who will want to come here? Has any thought gone into these long-term outcomes? None that I can see.

12. So what I see emerging is the process of doing away with a large swathe of small and medium sized practices of providers, who will be driven into being employees of a few large providers. The essential mechanics seem to be to wrestle control of health care revenues away from fee for service providers, and give the state control and leverage over healthcare providers, by centering the pricing and control of healthcare far away from the decisions of patients working with physicians, and as close as possible in the offices of the state negotiating with the contracting agent about what money is to be spent on healthcare in Oregon.

13. I certainly do not believe this way forward is either going to be wise medically or necessarily be cost-effective. I see the intent to do away with the doctor-patient decision process on how money is to be spent, and replace it with the top-down budget of a bureaucracy. Unsaid but certainly implied is that the state bureaucracy does not trust either physicians or patients to look out for the public interest. If one considers that point more deeply, however, certainly there are more positive ways for the state bureaucracy and legislature to react to that perception than just to remove the patient and the provider from the decision process. I think this fundamental point needs a wider discussion. I personally think the doctor-patient dialogue can learn to be frugal. I do not believe, however, that the state will coax much compliance from doctors/patients if the state does not show as much respect as it wants in return. If the state focused more on creating

incentives for both providers and patients to act frugally and work to achieve a "good outcome", then that type of reform should produce better results than the less people oriented reform the state seems to value. Carrots work better than sticks, so both patients and providers need to see they can "make money" by doing the "right thing". Case management codes that reimburse providers reasonably well for a "good outcome" and copays that go down for patients that meet defined benchmarks in their care (specific for each Dx) could be crafted to engage and encourage good behavior in both providers and patients.

14. It seems hardly necessary to point out that the state is mesmerized by its burden of healthcare costs at a time of extreme budget stress. It seems hardly necessary to point out that the state is not really motivated by the task of creating a "good" healthcare system right now, when for obvious reasons, its first goal must be cost containment. Everything else will be secondary until the budget crisis is dealt with. Furthermore, I personally think that the state has not altered its healthcare strategy one bit as a result of its public commentary periods over the last several years. I believe the state has no short term intention of doing anything more than is politically necessary to get its budget under control.

15. Could there be another way to proceed with healthcare reform? I certainly can think of some. Will the state allow other models to appear? I hardly think it will want to. But I do think it is obvious that the citizens of the state will eventually want the state to engage in creating a "good" healthcare platform, once the budget has been met. To my mind, the problem is partly the moral dilemma of insurance. It often breeds excessive entitlement when one is spending some else's money. There needs to be frugality at the point of providing service, right when the patient and physician are discussing alternatives. The state does not believe the doctor-patient relationship can do that. It is clear in the state's plans that there is no role for either the individual doctor or individual patient to have any meaningful say about what money is to be spent. No matter how the state wants to side-step this point, that is the way they are going.

16. Personally, I think doctor-patient relationships can be frugal and value driven. The constraint does need to be about the amount of money the patient has to spend and / or should spend on any given service. In

my world view, I favor the approach where the state could partition a budgeted amount of money into credits for patient-controlled health care accounts, and let them spend it in collaboration with the best provider advice they can get. People can be incredibly frugal when they are spending their own money. Resources going to these accounts could come from employers, government, self, family, etc, and the patient's could be required to use some of these monies / credits to get personal insurance. The money does not have to flow thru the bureaucracy. The bureaucracy simply believes that only they can effectively spend what needs to be spent.

17. Well, this debate can and certainly should still go on. I think Oregon should not be driven down a path of healthcare reform without public discussion and consent. I would like to see our healthcare plans put to a public opinion poll or actual vote, letting the public choose between the best two alternatives our political class can muster. In the entirety of the healthcare reform debate, the public is being given short shrift and little role. They are neither criticized for their role in driving up costs, nor offered a constructive role (a vote) in creating the way forward.

18. I hope the OHA can open its mind to allow alternative models to go forward in Oregon. In its haste to solve the current budget, I hope the planners for the way forward care enough to take the time to slowly create a viable and stable healthcare framework. We are all going to have to live with it for a long time.

19. As to the OMA, I hope they help providers find their voice. Considering the issues at stake, physicians in Oregon have been silent and passive for too long. I believe physicians have the ability to help society find its way on healthcare reform. I also think physicians have an obligation to speak out when healthcare in our society is at stake. Personally, I think we all took an oath to do so.

Respectfully submitted,

Joe Hassett, M.D.

From: "Pete Johnson" <pete.johnson@nbmconline.com>
To: <OHPB.Info@state.or.us>
CC: <oma@theoma.org>
Date: 3/5/2011 2:29 PM
Subject: Health System Transformation Team LC

Transformation team

A lot to digest. A simple but not so simple question. This approach seems to be I-5 centric with exception of Bend.

How would this apply to the more rural and non system care in Rural Oregon. The language on rural health clinics is vague at best.

Please give greater thought as to how this vision for Oregon impacts Oregonians east of the mountains and along the Coast.

Thank you

Pete Johnson

From: "Brian Kelly" <bkelly@whallc.com>
To: "OHPB.Info@state.or.us" <OHPB.Info@state.or.us>
CC: "OMA@TheOMA.org" <OMA@TheOMA.org>
Date: 3/5/2011 7:01 AM
Subject: Health System Transformation Team LC

In HSTT's legislative draft concept, I do not see patient protections comparable to the New Health Reform Provisions of Part A of Title XXVII of the PHS Act to Grandfathered Commercial Health Plan. Oregon should meet these minimum standards of patient protections. Per provision section §2719, group health plans and health insurance issuers offering group or individual health insurance coverage must permit an individual to select a participating primary care provider, or pediatrician in the case of a child. Provides direct access to obstetrical or gynecological care without a referral. Prohibits prior authorization or increased cost sharing for out-of-network emergency services.

Thanks for your consideration.

Brian Kelly

Brian P. Kelly
Chief Executive Officer
Women's Healthcare Associates, LLC
[WHA - EMAIL SIG logo - Vertical - Color - sm][100best4Web]

From: "don lagrone" <donlagrone@gmail.com>
To: <OHPB.Info@state.or.us>, <oma@theoma.org>
Date: 3/4/2011 6:33 PM
Subject: Health System Transformation Team LC

The devil is in both the details and their implementation. Health care for children under the current Managed Care contracts in the Portland metropolitan area are a good example. CareOregon as the dominant provider organization, has created a two tiered system for children by setting reimbursement levels for physicians so low that providers are loath to contract with them. Instead of compensating physicians sufficiently to encourage participation they divert care to school health clinics and Federally Qualified Health Centers, whose budgets are subsidized by funds from other sources. In the resulting environment families with Private Insurance may choose from the full spectrum of providers, including the many

well qualified Pediatricians in the Portland area, but those on Care Oregon find few physicians able or willing to provide their care. In the meantime Care Oregon bankrolls substantial financial reserves, public money which was

intended to provide care, and use those funds to finance additional alternative facilities staffed by complimentary providers. Complaints to State officials have fallen on deaf ears. If this is an example of how Accountable Care Organizations will be allowed to operate, the Legislative Concept will result in a further devaluation of the care of children in Oregon. Lofty slogans regarding the improvement of care do not translate into improved health for individuals. The expansion of OHP eligibility will provide real access to care only when those operating the system are prevented from subverting its goals to drive their own agendas. Don LaGrone, M.D.FAAP

From: "Nancy&Craig Leman" <lemann@onid.oregonstate.edu>
To: <OHPB.Info@state.or.us>
CC: "Nancy&Craig Leman" <lemann@onid.oregonstate.edu>
Date: 3/4/2011 11:26 PM
Subject: Health System Transformation Team LC

Thank you for sending this information. I have read through it and support it as written . I appreciate the OMA's cooperation with the team and am particularly grateful to Dr. Dannenhoffer for his effort.

In private practice at the Corvallis Clinic since 1957, I was a member of the OMA (when it was called OSMS-- a term that was dropped a few years later because our leadership felt it implied "socialism") till I retired in 2007. I perceived a need for a health system like this one every step of the way, as I constantly encountered unfortunate individuals who were left out by our existing system.

I am grateful that the OMA is working with, instead of against, this painful, thankless, time-consuming, controversial effort to establish an inclusive, accessible, health system. I regret that, at age 87, I lack the smarts, energy, and up-to-date knowledge of the contemporary workplace to do more than cheer for Dr. Dannenhoffer and his colleagues who are carrying the ball.
Craig B. Leman, M. D.

From: "John Mayberry" <mayberrj@ohsu.edu>
To: "OHPB.Info@state.or.us" <OHPB.Info@state.or.us>
CC: "oma@theoma.org" <oma@theoma.org>
Date: 3/6/2011 9:41 AM
Subject: Health System Transformation Team LC

Comments on Legislative Concept from President, Oregon Chapter of the American College of Surgeons

I read through the proposed legislation and just had a few thoughts/questions.

First, a lot of words are being changed to current lingo, but my question is, are these changes substantial? In other words, will we still have largely a private insurance model that pays fairly for services with a public model that underpays for services because the public budget just doesn't exist to pay fairly? Also, is the authority of the Oregon State government to control the private side of things increased by this legislation or stable?

Second, I hope the Oregon Health Authority realizes that quality health care is by definition expensive. You can't seriously hope to pay less for something and get more. Quality providers, facilities, and affiliated services, like technology (devices, electronic medical records, pharmaceuticals) are expensive and presumably worth the money. It's not always a matter of efficiency or 'integration', I think most of the time, quality care just plain and simple involves a good number of quality people, facilities, and technology that can't exist without fair reimbursement for service.

Third, as a surgeon, one thing I have experienced is that I occasionally have had Medicaid patients that could have benefited from a relatively simple surgery, such as an inguinal hernia repair, or other day surgery procedures, that was significantly impeding their ability to work, but the Oregon Health Plan would not pay for it. So instead the patient can't work or can't be hired for a job because they have a physical problem. Letters and phone calls from me to decision makers would get nowhere. I would like to see some mechanism where the fact that the patient's inability to get hired or work would be taken into account before the requested service is denied by Oregon Health Plan.

Thanks for your requests for comments. It would be nice to hear back from someone on these questions.

John Mayberry, MD
President, Oregon Chapter American College of Surgeons
Professor of Surgery, OHSU
mayberrj@ohsu.edu<mailto:mayberrj@ohsu.edu>
503-494-5300

From: "Jim Molloy" <walderse@viclink.com>
To: <OHPB.Info@state.or.us>
CC: <OMA@theOMA.org>
Date: 3/4/2011 8:57 PM
Subject: Health System Transformation Team LC

While I had been both a Medicare and Medicaid provider for many years, when

I chose to re-open a private rural family practice in July, 2006, I purposely chose to not participate in Oregon's Medicaid system. This was based solely on the fact that we would be unable to meet our office overhead by accepting the payments expected for care provided to OHP patients. We could not see placing our family's Century Farm in jeopardy because Oregon chooses to underpay rural primary care medical providers for the services they provide.

Since July 2006, not a week has gone by that we have not received at least a half dozen calls from OHP patients wishing to be seen in our offices. When told that we are not currently involved in the Oregon Health Plan, at least 50% of those calling then ask if they can just come in and pay cash for said services. We dutifully explain that it would be illegal for us to accept cash payment from anyone who we know has Oregon Health Plan. This pattern of

OHP patients being willing to pay cash for our services tells me several things. First, there is obviously a need for more primary care providers. Second, the financial screening of many OHP recipients does not accurately quantify the financial "strength" of many of these people. Finally, there should be another option available for care for OHP recipients. I shall explain in more detail.

Medicare offers the option for medical providers to "opt out" yet still care for Medicare-eligible patients under an individual patient-provider contract. If a Medicare patient values the care they receive from a provider who has "opted out", they have every right to pay for that care on their own without the federal government intruding on the patient-provider relationship. Since neither the patient nor the provider can bill Medicare

for said service, the government saves money by not paying for a claim yet makes money on the taxable income paid to the provider directly. Why would

someone with Medicare benefits forego the use of those same benefits to see a provider who has "opted out"? Because they know they are getting their money's worth and understand the value of hard work and a job well done. Quality, efficiency, autonomy and the understanding that the patient-provider relationship is paramount over all others. They do it because they believe Patient Care Comes First!

My suggestion is a simple one: Allow OHP recipients to enter into individual

contracts the same way patients with Medicare are allowed to do. If an OHP enrollee has enough economic depth to seek out and pay for medical care outside the OHP system, the state of Oregon saves money on a claim not requiring payment yet can receive higher tax revenue from the medical practice's increased income.

If you have any questions, feel free to contact me.

James P. Molloy III MD, FAAFP

Western Yamhill Medical Center

Sheridan and Willamina, Oregon

From: <Erik.Swensson@capellahealth.com>
To: <OHPB.Info@state.or.us>
CC: <OMA@theoma.org>
Date: 3/7/2011 5:02 PM
Subject: Health System Transformation Team LC

Sir: I am Erik Swensson MD FACS who has been a Vascular and General surgeon for 25 years and Chief Medical Officer of Capella Healthcare for the past few months. As the OHA and the governor have stated everything is on the table. Unfortunately this has not included liability reform. Even the OHA task force on liability reform came up with now real plans for change. This is not acceptable nor is it in line with "everything on the table." 85% of doctors admit to regularly practicing defensive medicine and I would argue it is 100%. This costs the country 60 to 200 billion dollars a year. Enough to fund insurance for everyone in this country without government over reach. Everyone agrees the present liability system does not help the vast majority of injured patients and does not educate doctors about their mistakes so they can improve. And yet the lawyers and others continue to say nothing can or should be done. Without a fundamental change in the system ,over testing will continue and with it the largest waste in the healthcare system will continue. I propose starting new and recognize that trial lawyers will be for the most part be, cut out of the system. But is this system for them or for the patients. Any patient injured should have the ability to have their case reviewed by a panel of medical experts and their decision will be mandated to be part of any court processes if the patient is unhappy with the panels' decision and decides to go to court. If it goes to court and the plaintiff loses they pay the court costs. If they win the court costs are paid by the defendant. I would be willing to be on a task force that puts something like this together but the governor must give it his support from the outset and demand that a new system of taking care of the injured in the medical system is implemented. Having their backs covered will allow doctors to stop practicing defensive medicine. Erik Swensson

March 7, 2011

To: Tina Edlund, Chief of Policy, OHA

Fr: Kathleen, O'Leary, Chair, Coalition of Local Health Officials
Morgan D. Cowling, Executive Director, Coalition of Local Health Officials

Re: Feedback on the Legislative Concept creating Accountable Care Organizations

The work of the Health System Transformation Team is important to fulfill the Triple Aim goals set by the Health Policy Board. For Oregon to achieve the goal around population health it is imperative that public health and prevention have roles in the Accountable Care Organizations (ACO).

The world of health care and public health is changing. As we get closer to the insurance mandate created by the Affordable Care Act the need for safety net services may change – but the demand for providers will not change and in fact may increase. Public health has a key role as a community provider of preventative services for both the Medicaid and uninsured populations. In order to assure population health, access, accountability, and equity, we all will still need a viable safety net in addition to the Accountable Care Organizations and their covered members. It is important that we build on the solid foundations in place even as we change the way we do business.

While the Coalition of Local Health Officials has not had time to thoroughly vet the legislative concept proposal we wanted to bring a couple of points to your attention:

- Counties acting as their role of the Local Public Health and Mental Health Authorities are investing time, energy and significant resources into local services. In this environment of fewer resources it is imperative that there be a formalized relationship between the new structures and the safety net mental health and public health services – to maximize the available resources.

Currently local public health provides vital preventative services to the Medicaid and uninsured populations in Oregon. Referencing local public health in the statutes related to ACO's will help assure continued Medicaid funding for these crucial services and programs.

- Because of many of the aforementioned concerns the Coalition of Local Health Officials would like to support language submitted by the Metro

Counties formalizing a relationship between the ACO and Local Mental Health and Public Health Authorities:

- *The applicants shall be required to establish a formalized relationship with local mental health authorities and local public health authorities which consists of coordination and significant influence in decision making. Applicants are required to get approval of the county authorities in each county where they intend to provide services.*

Thank you for the opportunity to provide comment and feedback to the Legislative Concept.

DATE: March 7, 2011

TO: Tina Edlund, Deputy Director, Oregon Health Authority

FROM: Administrative Council, Central Oregon Health Authority

RE: **Feedback to the Healthcare Transformation Taskforce
Regarding Proposed Legislative Concept**

We appreciate the opportunity to offer input on the 2/28/11 Legislative Concept. This feedback is consistent with the work we have been engaged in with the Oregon Health Authority over the last 18 months. Membership of our Administrative Council is listed at the end of this memo.

We continue to see merit in having a regionally-based approach to funding, planning, policy development and service delivery to improve the overall health of our population and the effectiveness of our delivery system. These benefits include:

- ❖ The capacity and accountability provided by local government combined with the assets and expertise of the private sector;
- ❖ Creation of a culture of collaboration and transparency among all health and health care stakeholders within a region;
- ❖ Assurance that housing, employment, food, economic security, educational and public health needs are considered alongside healthcare needs, especially with safety net populations;
- ❖ The essential coordination with the public health and mental health authority responsibilities of County government.

We understand that the concepts outlined in this memo may fit into the existing LC, or may require companion legislation. We welcome your guidance on this matter as we look to continue our work on an accountable health care and services system.

Legislative Concept Recommendation:

1. Addition to 414.725 (1)(a) (or immediately after in new (b)): **Where they have been formed, the Oregon Health Authority will delegate contracting for the services provided by ACOs to OHA approved, regionally-based organizations known as “Regional Health Authorities” as defined in statute 414.xxx. The Regional Health Authority will assume or may delegate all subsequent statutory responsibilities as defined in ORS 414.725, 431.416 and 430.630.** (other citations will likely be needed).

2. Recommended requirements of a Regional Health Authority:
 - a. Allows two or more contiguous counties to form a “Regional Health Authority” (RHA); requires the approval of RHA designation by the Oregon Health Authority.¹
 - b. The Governing Board of the RHA shall include: local elected officials, local leaders in education, consumers of physical and behavioral health services, health professionals and the business community.
 - c. The RHA shall have an Administrative Council responsible for advising the RHA Governing Board on strategic and operational matters, developing projects and action plans in support of regional policies (including critical investment priorities), the regional Health Improvement Plan and our desired health outcomes.
 - d. Membership of the Administrative Council shall include: county public health and behavioral health officials as well as representatives from the hospital system, safety net clinics, accountable care organization(s), provider association(s), long term care providers, and dental providers.
 - e. RHAs are local policy making and monitoring entities which can promote collaboration between key stakeholders and providers. RHAs are not allowed to contract to be Accountable Care Organizations.
 - f. RHAs may seek resources and contract for other health initiatives or services to further the health of the region.

3. Functions of an RHA (could be in this statute or separate statute):
 - a. The core function of a Regional Health Authority is to allow local communities to be fully engaged in developing population health and in the design and delivery of health care in their geographic area.
 - b. The Oregon Health Authority shall work collaboratively with designated and approved Regional Health Authorities in the contracting with and continuous oversight over any Accountable Care Organization servicing that area.
 - c. In collaboration with local public health agencies, ensure baseline health and economic data on the region’s residents at the inception of the RHA and on a periodic basis so as to track and modify the Regional Health Improvement Plan and to promote public accountability for health outcomes in lieu of individual county or agency planning requirements not otherwise required by federal agencies.
 - d. RHAs shall complete a Regional Health Improvement Plan, which publicly shapes the development of the local care system. The Regional Health Improvement Plan shall document the engagement of the community in the planning process. The plan shall be consistent with the Triple Aim of improved patient experience with the health care system, improved health of the population, and decreased costs of

¹ We understand that this may be rewritten to reflect a smaller configuration than we have proposed. We would simply ask to be reassured that a multi-county arrangement is feasible.

health care. This plan shall set critical investment priorities for the region.

- e. RHAs shall conduct their business in such a way as to promote public accountability and transparency in processes and activities.
- f. RHAs shall ensure that Accountable Care Organizations deliver services in such a way as to be consistent with the Regional Health Improvement Plan.
- g. RHAs shall create mechanisms to document savings as they occur, with a strategy for reinvestment of such savings in communities and programs consistent with the regional plan and consistent with promoting the Triple Aim.
- h. Recognizing the social and economic factors affecting health outcomes and health expenditures, RHAs shall promote collaboration between health care delivery systems' social service systems and non-profit organizations within the region.
- i. Local government and non-profit involvement insures that housing, employment, food, economic security, educational and public health needs are addressed alongside healthcare needs, especially with safety net populations.

Central Oregon Health Authority Administrative Council:

Scott Johnson, Director, Deschutes County Health Services, Admin-Council
Chair

Dan Stevens, Sr Vice President, Government Programs, PacificSource Health
Plans, Admin-Council Vice-Chair

Robin Henderson, PsyD, Interim Director, Health Integration Projects, St Charles
Health System, RHA/Admin-Council Staff

Alisha Fehrenbacher, Executive Director, HealthMatters of Central Oregon

Jeffrey Davis, Consultant, Jefferson County Health Services

Kat Mastrangelo, Executive Director, Volunteers in Medicine

Megan Haase, FNP, CEO, Mosaic Medical Group

Muriel Delavergne-Brown, RNBS, Director, Crook County Public Health

Rick Treleaven, LCSW, Director, BestCare/Jefferson County Mental Health

Scott Willard, MA, Director, Lutheran Family Services/Crook County Mental
Health

Seth Bernstein, PhD, Executive Director, Accountable Behavioral Health Alliance

Tom Machala, Director, Jefferson County Public Health

March 7, 2011



Bruce Goldberg, M.D.
Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097 (503) 781-7179

Re: Response to HSTT legislative concept

Dear Bruce:

On behalf of Providence Health & Services I am pleased to have the opportunity to provide comments and feedback on the proposed legislative concept currently under consideration by the Health System Transformation Team.

Providence commends the Oregon Health Authority and the Health System Transformation Team for putting forth this draft legislative concept for implementation of regional model of person-centered accountable care. We see many parallels between this proposal and our own journey of integration and delivery system reorganization. Providence supports the transformation of health care delivery and financing through new clinical care models and payment models. Our own integrated model of care places the patient at the center of everything we do, and we too measure our success by the Triple Aim objectives of improved health outcomes, improved patient experience and affordability. The Providence clinical care transformation includes medical home pilots, breast care navigators, standardization of medical orders and medical lists, and care delivery pilots focused on improved outcomes for patients with diabetes or breast cancer.

We recognize that current growth in health care spending is unsustainable and continues to be an increasing burden on government, private purchasers, business and individuals. We also understand and accept the aspiration to move aggressively to keep spending within a global budget. At the same time we must be ever mindful of unintended consequences and unknown impacts that are sure to come as health care reform is implemented. In addition to a spending target, it is equally important to have in place structures for monitoring and measuring the factors contributing to increased health care costs, and then apply appropriate risk adjustment mechanisms. This measurement and feedback loop will help ensure that reform efforts are focused on the correct levers that impact cost and quality; and, the risk adjustment mechanism will help mitigate the adverse impacts that are likely to occur during the transition.

We offer the following suggestions to improve the workings of the regional ACO structure and bring more clarity and predictability to this innovative model of care delivery

Oversight of ACO financial condition and risk adjustment-- leveling the playing field

Providence applauds the HSTT for addressing the need for “the authority to assess the financial condition of each accountable care organization.” There must be recognition that ACOs will be taking significant financial risk, similar to a health plan, without the financial or regulatory oversight associated with health plans. ACOs that assume a global budget will need sufficient resources to continue operations even when exceeding their budget. An under-capitalized ACO that can no longer provide care could jeopardize the delivery systems in a community. This phenomenon occurred frequently during the 1990’s, when there was a significant push to capitated payments and managed care.

- We recommend that the legislation provide for strong financial oversight of ACOs by the Oregon Health Authority, and that these standards be specified in statute. There must also be protections built into the

system to maintain the financial stability of the ACOs. Oregon is embarking on system changes of a magnitude that have never been attempted, and the financial failure of ACOs could have major consequences on numerous levels. One possible solution is that during the first five years of this program, an annual limit on total financial loss exposure should be established for those ACOs meeting quality metrics and standards.

- We recommend that the legislation specify risk adjustment mechanisms to account for different patient acuity and adverse selection issues within the populations served by the ACOs, and between the ACO regions. These could include an aggregate or individual stop loss/reinsurance for outlier cases; a high-risk pool shared among all ACOs in the state; other mechanisms?

ACO selection process

The ACO selection methodology will be vital to the eventual success of the program. Providence supports setting high standards for quality of care, breadth of services and financial reserves. Using a selection system similar to that of the Medicare Advantage program would allow only qualified ACOs to participate in care delivery while also allowing for competition in the market. The Medicare Advantage model is preferred because it allows more players to participate, has a demonstrated track record, and has shown to be effective, especially in Oregon.

- The legislation should specify an appropriate numbers of ACOs for each region, weighing the population and provider base. For example, the legislation could specify a ratio of one ACO for every 50,000 covered lives in a region.
- A conscience clause should be included in the selection process, to allow organizations with religious or moral limitations to participate while still serving their missions.

Care Delivery

- There is a need for waivers or other federal or state action to provide safe harbors from federal statutes and regulations such as Stark, EMTALA, Anti-Kickback and Civil Monetary Penalties laws, anti-trust enforcement and tax policy and licensure/certification requirements -- all of which act as barriers to clinical integration and provider collaboration needed to facilitate formation of ACOs, new delivery models and payment models such as use of bundled payments. These statutory and regulatory barriers present an opportunity to seek guidance from CMS and the DOJ on appropriate alternatives or waivers, and this should be called out in the legislation.
- The legislation should specify that providers may belong to multiple ACOs. This issue will become critical as the regional ACO platform is expanded to serve populations beyond Medicaid and the dual eligibles. For example, an ACO provider panel structured to serve the Medicaid population may not have the capacity or provider mix to serve other market segments. But some providers within this panel may seek to serve other populations and should not be restricted.
- The legislative description of the continuum of care to be covered by the ACO is broad. It includes medical, dental, and mental health coverage as well as long term care and other support services. Throughout the draft there are multiple reference to support, e.g., long term care supports, support services, supportive needs, services supporting independence. Nowhere are these terms defined. Consistency in these terms is needed, along with a clear definition of the service delivery expectations. This will prevent future disputes over the scope of support services to be provided. For example, the purchase of a \$500 air conditioner for a COPD patient may be a reasonable support service; but how far will an ACO be expected to go to provide "services supporting independence and continued residence at home or in [the] community?" Must an enrolled quadriplegic member be provided with a \$50,000 home remodel for independent living? Providence recognizes the healthcare needs of a person are often multidimensional requiring flexibility in the delivery of care through alternate models with reasonable supportive services. However, ACO's responsible for all care costs will require some clear and defined limits around social services, long term care and similar services in order to manage expectations and plan for contingencies.

Community involvement in the cost of care -- encouraging all providers to play or pay

Historically, many health care providers have delivered care to Medicaid members at reimbursement levels

below the actual cost of care. Even within a reorganized delivery model that achieves delivery efficiencies, the ACO's margin will likely be small or negative for this population. As the regional ACO platform is expanded to other "commercial" market segments, new ACOs will move into the market to cherry pick these members. The regional ACO structure will be most successful if the financial burden of providing care for all populations and market segments is spread among all providers and ACO within the region's healthcare system.

- Providers not participating in a Medicaid ACO should be financially responsible for some portion of the cost through a fee or tax on medical claims. For example, this assessment could be tied to the ratio between the number of Medicaid lives and non-Medicaid lives. A sliding scale would impose a higher assessment on providers and ACOs serving fewer low-income members. This will help ensure that cherry picking the populations served does not undermine the success of the program.
- An appropriate financial adjustment must also recognize the contribution of delivery systems providing uncompensated services and community benefit to undocumented low-income persons not eligible for Medicare or Medicaid, and not otherwise eligible to purchase subsidized coverage through the exchange. This disparity will be most evident between not-for-profit and for-profit providers.

Contracted ACOs

The legislation should clearly differentiate between the standards for participation in a regional ACO serving the Medicaid, dual and triple eligible population; and the standards for participation to serve other market segments. The unique needs of the Medicaid/dual population will necessitate distinctive ACO partnerships (i.e., FQHCs, safety net clinics, long-term care services, wrap-around services and other community support services). There must also be distinct statutory requirements for regional ACOs serving expanded populations such as Medicare, PEBB/OEBB/other governmental employees, and individuals/small groups purchasing through the exchange.

- There needs to be more definition and guidance on the key requirements for ACOs, particularly around the tools ACOs can use to reduce costs and prevent over and under utilization. Perhaps modeling this after the federal requirements would be appropriate.
- We recommend that the legislation specify that ACOs serving market segments beyond Medicaid/duals be required to meet health insurance or health care service corporation licensure standards, financial standards and rate and form standards. This will provide a level playing field for entities serving the traditional commercial populations, and provide appropriate protection and safeguards for the public and the state.
- The length of the contact term for a regional ACO should be specified. A multiyear contract award is necessary due to the significant financial resources required to create the ACO organization, the technology investment, the care coordination structures, and the contracts necessary for a fully functioning ACO. We suggest a contract term of five years be specified in the legislation.
- Minimum guaranteed funding levels must be specified to provide predictability to prospective ACOs. For example, a formula for annual rate adjustment during the term of the contract could account for changes in cost and demographics. The legislation should specify a "maintenance of effort" requirement to be met by the state. This requirement is necessary because ACOs accepting a global budget cannot be open to the risk of year-to-year payment reductions due to state budget issues.

Medical liability/tort reform

Appropriate medical liability reforms must be implemented in light of the risk to be assumed by ACOs caring for the populations in this regionalized, globally capitated structure with statewide standards and evidence based protocols. These reforms must address both the concerns of the direct costs of the current medical liability system, as well as the indirect costs of defensive medicine.

- We recommend that a maximum liability exposure of \$500,000 per occurrence be established for an ACO and its providers complying with the OHA evidence-based protocols, practice standards and shared decision making. Compliance with these protocols and standards could essentially become a safe harbor.

Miscellaneous

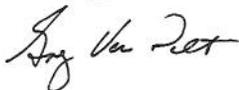
- The legislation should explicitly state that collaboration with local communities and governmental entities is encouraged, but administrative and regulatory oversight remains with the OHA. It would not

be appropriate to create additional costly levels of regulatory and administrative oversight at the local or regional level. An additional layer of local regulation could also lead to inconsistent and conflicting administrative standards between regions. This is problematic for integrated delivery systems operating in more than one region, and will only add to cost and complexity.

- It should also be explicitly stated in the legislation that regulatory and administrative burdens be minimized. Wherever possible, state standards should mirror federal standards for data collection, reporting and other administration. This should also include requiring the state to maintain consistency of certification, regulatory and reporting requirements for person centered medical homes with federal and commercial plans. Such consistency would reduce unnecessary variation in the administrative burden of providing care. Other examples of regulatory minimization include consideration of moving away from requiring traditional claims data if unnecessary from a global payment prospective. All of this will simplify administration, and reduce redundancy and duplication of effort.
- Shared savings between the state and federal government is contemplated. The legislation should explicitly state that providers and ACOs will also participate in the shared savings.
- In the draft amendments to ORS section 414.725 and the new statutory section that follows reference is made to the essential elements for ACOs, including “alternative innovative integrated health and services” and “alternative integrated care systems.” Neither of these terms is defined and this should be clarified in the legislation.
- Alternative payment methodologies [section 414.620(3)] should state that a balance between volume and quality is appropriate, rather than quality alone. This balance is consistent with achieving the triple aim objectives.
- The language in the new section on essential elements for ACOs [414xxx1(a)], states that the ACO is accountable for “working cooperatively with community partners.” This phrase needs to be defined and clarified so that ACO contractors and member can understand expectations regarding these relationships and the types of community partners with whom collaboration is required. Similarly, in subsection 2(c) it states the ACO must provide access to services and supports that are “geographically located as close to home as possible, including use of community health workers and nontraditional settings that are accessible to families....” More clarity and definition is needed so that ACOs and members can understand this expected standard. What types of community health workers are to be included in the care team, and what is the ratio of members to such workers? What types of nontraditional services and supports are expected to be provided? For example, would these services and supports include telephonic patient support and e-visits; or are ACOs also expected to include in the medical home non-allopathic providers? And finally, what are the geographic accessibility standards? In this regard, see also amendments to ORS section 414.760(2). We suggest that the legislation specify that geographic accessibility follow national standards.
- Within the definitional section at ORS 414.025, new terms are referenced, but not defined. For example, at subsection (5)(d) the phrase “long term care services and supports” appears with no further definition. At subsection (5)(t) the term “home and community based services” appears with no further definition. In subsection (10), the phrase “alternative innovative integrated health and services” is used with no further definition.

Thank you again for the opportunity to comment on this important legislative concept. I look forward to working with you and the other members of the HSTT as we finalize our discussions around this legislation, and then quickly move forward with the structural delivery system changes needed to improve population health and outcomes, improve the patient experience, and improve overall affordability. Please let me know if you would like to discuss any of these comments in more detail.

Sincerely,



Greg Van Pelt
Executive Vice President/Chief Executive - Oregon



Health System Transformation Team Legislative Concept

Proposed Revisions

Reproductive health must be **explicitly listed** as necessary for integration along with (physical health, mental health, addictions treatment, oral health, home and community based services and long term care services and support) or the fragmentation that currently exists between primary care and reproductive health will be propagated under this new system.

- Women spend on average 30 years trying not to become pregnant.
- 48% of pregnancies in Oregon are unintended.
- Approximately 70% of women who had an unintended pregnancy gave reasons that demonstrated they lacked comprehensive contraception advice from a clinician.

Over the last 20 years reproductive health has been siloed and separated from women's primary health care. It has been assumed in statute that physical care/primary care includes reproductive health care, but in practice it has been excluded. The delivery system most often does not recognize reproductive health as an essential service to be integrated into primary care.

However, the **ongoing need for reproductive health** has many of the characteristics of a chronic health condition requiring frequent monitoring and oversight by primary care. The current reimbursement system recognizes and rewards family planning only providers. Family planning services are only reimbursed when it is a separate service from primary care.

Therefore, we respectfully ask the Oregon Health Policy Board to **explicitly list** reproductive health as necessary for integration along with these other services.

Below you will find our recommended changes to the Health System Transformation Team's Legislative Concept. Please see additions in **bold**.

Key features of LC discussion draft: Goals and policies for integrated health care and services **2nd Bullet:** "Care and services are integrated and coordinated, including physical health, mental health, **REPRODUCTIVE HEALTH**, addictions treatment, oral health, home and community based services, and long term care services and support."

Under the statutory amendment **414.725 (b)**: “It is the intent of ORS 414.705 to 414.750 that the Oregon Health Authority use, to the greatest extent possible, accountable care organizations receiving global payments to provide integrated physical health, dental, mental health, **REPRODUCTIVE HEALTH**, chemical dependency, home and community based, and long term care and support services under ORS 414.705 to 414.750.”

Under the statutory amendment **414.018 Goals; Findings (3) (a)**: “All health care and services are coordinated, including physical health, mental health, **REPRODUCTIVE HEALTH**, addictions treatment, oral health, home and community based services, and long term care and support.”

Please contact the Oregon Foundation for Reproductive Health with any questions:

Michele Stranger Hunter, Executive Director
(503) 223-4510
Michele@prochoiceoregon.org

From: "METZGER Kay M" <KMETZGER@lcog.org>
To: "'Tina D EDLUND'" <tina.d.edlund@state.or.us>
Date: 3/7/2011 6:11 PM
Subject: RE: Health System Transformation Team FOLLOW UP

Tina,

Thank you for the opportunity to provide input on the proposed Legislative Concept. Briefly, here are my initial comments on the draft language.

Part 1 - Goals and Policies

This section mentions "global" budgets several times. The definition of global could be interpreted several ways. For example, the current long term care system is operated under a statewide system which could be considered global in nature. Under this system consumers, no matter where they live, are assessed using a standard tool that is highly developed. Long term care benefits are determined and authorized using this standardized, detailed and prescriptive tool. Funding and payments for long term care services is managed state-wide. Under this type of managed system using a standardized assessment tool and global budget, Oregon has achieved much recognition as having a very cost effective and extremely successful long term care system.

Part 2 - Delivery System Changes

During our HSTT meetings it has been repeatedly stated that the system is broken and there is a severe problem with out of control health care costs. Conversely, there has been recognition that the model of long term care currently in place has been exceptionally efficient and effective over several decades. As stated above, this model is indeed a very successful "managed" model. However, the proposed Legislative Concept language moves long term care away from its successful social model into a medical model which clearly is having problems. This is not the right direction.

Provision of human services for seniors and people with disabilities in long term care programs should not be housed under medical managed care organizations. Rather, the best care would be provided by a mandatory coordination (as opposed to full integration) between a social long term care case manager and a member of the individual's medical primary care home or managed care organization.

Thank you,

Kay Metzger

Chair, Oregon Association of Area Agencies on Aging and Disabilities

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From: Tina D EDLUND [mailto:tina.d.edlund@state.or.us]

Sent: Thursday, March 03, 2011 12:01 PM

Cc: Alissa ROBBINS; Amanda SUTTON; Amy FAUVER; Bob Diprete; Bobbi DOAN; Bruce GOLDBERG; Carolyn WILSON; dbianco@comcast.net; Diana WOODS; Jeremy VANDEHEY; John A SWANSON; Judy MORROW; Julie EARNEST; Karynn FISH; Kathryn L MIKESELL; Katie L SMITH; Linda D GRIMMS; Margie Fernando; Mike BONETTO; Richelle BORDEN; Sean KOLMER; Suzanne HOFFMAN; Tina C KITCHIN; Tina D EDLUND

Subject: Health System Transformation Team FOLLOW UP

Importance: High

Team Members,

I'm attaching the legislative concept language from last night as a separate document for your review and comment.

We are looking for specific and substantive feedback to the framework and language for delivery system transformation as it's envisioned in this concept. If there are areas that need additional clarification or elaboration, please let us know that as well. It will be a great help if you reference which part (1-4) and section your comments are directed toward.

We will accept comments up until noon on Tuesday, but I would ask that everyone have something to me by the close of business on Monday, March



ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS

Addictions • Mental Health • Developmental Disabilities

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Community Counseling Solutions
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Baker County
Mountain Valley Mental Health Programs, Inc.

Benton County Mental Health

Clackamas County Health, Housing
& Human Services

Clatsop Behavioral Healthcare

Confederated Tribes Community Counseling
Center of Warm Springs

Coos County Mental Health

Crook County Mental Health
Lutheran Community Services

Curry County Human Services

Deschutes County Mental Health Department

Douglas County Health and Social Services
Grant County Center for Human Development

Harney Behavioral Health

Jackson County Health and Human Services

Jefferson County
BestCare Treatment Services

Josephine County
Options for Southern Oregon, Inc.

Klamath County Mental Health

Lake County Mental Health
Lutheran Community Services

Lane County Health and Human Services

Lincoln County Health and Human Services

Linn County Health Department

Malheur County
Lifeways, Inc.

Mid-Columbia Center for Living
Sherman, Hood River & Wasco

Multnomah Health and Addiction Services

Polk County Mental Health

Tillamook Family Counseling Center
Umatilla County

Union County
Center for Human Development, Inc.

Wallowa Valley Center for Wellness

Washington County Behavioral Health &
Developmental Disabilities Division

Yamhill County Health and Human Services

March 8, 2011

To: Tina Edlund, Deputy Director of Policy and Planning
Implementation, Oregon Health Authority

From: Gina Nikkel, Executive Director, Association of Oregon
Community Mental Health Programs

Re: Feedback on the Oregon Health Authority's proposed legislative
concept

The Association of Oregon Community Mental Health Programs (AOCMHP) appreciates the opportunity to comment on the specific proposed legislative concept that was introduced to the Health Transformation Team on Wednesday evening, March 2, 2011.

AOCMHP wants to underscore the importance of local accountability that is responsible for achieving an agreed upon set of outcomes. We endorse the addition of language that should be included in the legislative concept after the first sentence in 414.725 (c) please insert:

The applicants will be required to establish a formalized relationship with local mental health authorities and local public health authorities which consists of coordination and significant influence in decision making. Applicants are required to get approval of the county authorities in each county where they intend to provide services.

Local government is responsible for much of the safety net and these systems are significantly impacted by the decision of any potential care organization managing OHP lives. County Mental Health Programs,

County Public Health Programs, and Oregon Health Plan Mental Health Organizations (MHO's) have specific expertise in the management of complex systems of care to the most vulnerable and challenging citizens with severe mental health and chemical dependency disorders not available anywhere else in the health care system.

We support the Triple Aim goals and request that you engage in conversations with the Local Mental Health and Public Health Authorities responsible for sections of ORS 426 and 430 as we think through the management part of the redesign.

AOCMHP wants to assure this redesign project succeeds and would offer our help in convening local community health discussions with Boards of County Commissioners.

March 7, 2011

To: Mike Bonetto

From: Janet Bauer, Policy Analyst, Oregon Center for Public Policy

Re: Comment on Legislative Concept for Health System Transformation

Thank you for the opportunity to comment on the draft legislative concept document for changing Oregon's health system proposed to the Health System Transformation Team on March 2, 2011. The following are our comments.

1. We appreciate that the concept does not erode current rules regarding eligible populations and covered benefits. We need clarification regarding how the statement that the concept does not erode benefits conforms to the Governor's proposal to eliminate 38 diagnosis-treatment pairs from the prioritized list. We believe that expansion of current levels of covered benefits would allow Oregon to better meet the legislation's aim of improving health and reducing costs. Therefore, we believe that expansion of covered benefits should be considered in this light.

We observe that *Part 2, Delivery System Changes, New Statute to adopt "Essential Elements" integration and accountability standards*, states that "Accountable care organizations are responsible for the full continuum of care for a defined population. In order to achieve that goal, accountable care organizations will need to provide comprehensive benefits, which will mean that some benefits now listed outside the required prioritized diagnosis-treatment pairs will need to be provided. Again, we urge that use of the prioritized list be re-evaluated for its appropriateness in light of the new goals of population health. It is our assessment, that while the scope of covered diagnoses should be expanded to adequately reach the legislative goal, treatment decisions could be guided primarily by research-based effectiveness measures.

2. We note that *Part 2, Delivery System Changes, (5)* is not written understandably. If the intent of the section is to state that a health care provider who does not provide services that typically conform to standard medical practice should let the ACO member know the services are indeed typically provided but will not be provided, we question why a provider would be allowed to withhold such services. If the intent of the section is some other meaning, this should be clarified and the public should be allowed to comment on the revised language.

3. We advise removal of the words, "caseload growth," that appears in *Part 1, 414.620 System established (1)*. We do not believe the concept of "caseload" is relevant to the system described in the legislation. The term is not defined and it is not referred to elsewhere in the document. A system that focuses on prevention, remedial and supportive care services emphasizes engaging individuals, not on reducing contact with individuals as the mention of reducing caseload growth suggests.

4. We affirm the concept that Accountable Care Organizations are engaged as a means of system change, and that a principle of point of accountability is provision of quality care. The legislative language should be amended to describe the standards by which quality care will be measured, if not in specific detail, by designating a credible authority the state structure, the Accountable Health Care and Services System, would use as its standard for measurement. Further, the legislation should be amended to define the method and frequency of evaluation on the quality measures and the specific quality threshold that would need to be met for contractors to be compliant. We recognized that the matter of quality standards is referenced in *Part 2, New Statute to adopt “Essential Elements,” integration and accountability standards, (5)*, however, the standard needs to be fully described in a discrete section appropriate to its importance, as noted here.

5. We affirm the language in *Part 2, Delivery System Changes, New Statute to adopt “Essential Elements” integration and accountability standards (1)(a)* that “the organization is accountable for the overall health of children and adult members in their area,” is appropriate. We believe that for this language to be effective, it must be operationalized. Language should be included that describes how overall health in an area is measured and to what standard of health the ACO will be held responsible for. While activities such as working cooperatively with community partners to address public health issues will likely be important in this goal, performing cooperative activities cannot be the accountability measure. Health standards must be defined.

6. We affirm the language in (b) of the section referred to in comment #5, above, that states, “Health equity is prioritized and disparities are reduced.” The legislation should be amended to describe how disparities are measured and what the standards are for acceptable reduction in them.

7. We affirm other elements in *Part 2, Delivery System Changes, New Statute to adopt “Essential Elements” integration and accountability standards* are strong and important elements of an effective, efficient delivery system including consumer input, person-centered care homes, integrated care, emphasis on providing choice and independence, stable primary care relationships, comprehensive transitional care, geographic access, use of non-traditional settings as care homes accessible to families in diverse and underserved populations. We also affirm use of information technology to facilitate coordination of care.

8. We affirm establishment of strong safeguards for consumers (*Part 2, Delivery System Changes, New Statute to adopt “Essential Elements” integration and accountability standards (2)(e)*). The safeguards need to be defined or reference to a credible authority on consumer safeguards made.

9. In the *Key Definitions* section we do not know why definition of medically needy would be omitted as noted in (7) of the section. We aren’t aware that there is no medically needy category. Further, if there is indeed none at this time, the definition should remain in the event the medically needy category is reinstated.

10. In the *Key Definitions* section, “global budget” should be defined.

11. We note that the new system envisions coordinating with non-health services to achieve health outcomes. This is noted in *Part 2, Delivery System Changes, New Statute to adopt “Essential Elements” integration and accountability standards (4)(c)*. Housing is an example of such critical non-health services that comes to mind. Since discussions are underway in congress and in our state house to dramatically reduce resources for such services, the Oregon Health Authority should lobby for preservation of such vital critical services on both federal and state levels. Or, another plan should be launched to address the reality that social conditions outside of the health delivery system critically impact health system outcomes.

From: <pamdv1@comcast.net>
To: "Tina D EDLUND" <tina.d.edlund@state.or.us>
Date: 3/7/2011 8:52 PM
Subject: Re: Health System Transformation Team FOLLOW UP

414.025 Definitions

(5) (e) and (f) --why is it necessary to have physician services as a separate line item and then medical care furnished by licensed practitioners in next line item. Should "physician" be changed to the generic "provider" terminology as it has been throughout the rest of the document?

Does an ACO have to be a primary care home or is this just a suggested model? 414.760.
How strong is the word "encourage" meant to be in this section?

(From: Pam Devisser)

Scott C. Hege

March 7, 2011

Governor John Kitzhaber
900 Court St NE
Salem, OR 97301

Governor Kitzhaber,

I appreciate the opportunity to provide feedback regarding the Health Transformation Team. As a county commissioner and a member of Association of Oregon Counties (AOC) we strongly support the necessity to redesign Oregon's health care delivery system to meet the Triple Part Aim goals of Better Care, Better Health and Lower Cost.

The discussion that has been focused on the local provision of physical and mental health care is needed. It is with this in mind that I would like to comment on the process and suggestions for the legislative concept of the Medicaid system redesign and the ensuing Request for Proposals (RFP) for Accountable Care Organizations (ACO).

Address

6580 Martin Road
The Dalles, OR 97058
p 541.298.1075
c 541.980.9636

Any list of fundamental elements for Accountable Health and Long-Term Care Services must include a working partnership with the local public and mental health authorities if they are to succeed in integrating the services, supports and potential health intervention points in a population-based manner. County Commissioners are, by statute, the mental and public health authorities.

Additionally, Commissioners are the elected officials that are closest to the patients and the public holds us accountable for these services. Millions of county general funds are used annually to support the community mental health and public health services. County Commissions are an integral part of the system.

The discussions being held at the Health System Transformation Team will lead to changes in the delivery system of which we are a crucial part. It is important that the Commissioners have the opportunity to contribute to the discussion on the RFP and the structure of the ACOs. A Commissioner should be invited to the table or be offered some way of contributing directly to the decisions affecting the system for which we are held accountable.

AOC stands ready to discussing this further at your convenience.

Sincerely,



Scott C. Hege

From: <Daniel.J.Field@kp.org>
To: <tina.d.edlund@state.or.us>
CC: <bruce.goldberg@state.or.us>, <mike.bonetto@state.or.us>
Date: 3/8/2011 12:32 PM
Subject: Kaiser Permanente comments on Health Systems Transformation Team
Legislative Concept

Tina:

Thank you for this opportunity to comment on the first draft of the Oregon Health System Transformation Team's legislative proposal. We've reviewed the legislative concept and four discussion drafts and offer the following initial comments:

Legislative Concept

We strongly support the emphasis on the Triple Aim and the focus on providing integrated, coordinated, evidenced-based care through accountable care organizations. As an organization founded on the principles of aligned incentives and shared purpose among health plans, hospitals, and medical groups, we believe the ACO model will enable physicians, nurses, and health care staff to work collaboratively and provide proactive, comprehensive care to Oregonians.

As a general comment, we remain concerned about the proposed reimbursement levels and the ability for the state to actualize the vision in this draft with drastically reduced funding. To effectively transform the way care is provided, the state should seriously consider the appropriate level of investment required to increase the chances of success.

In addition, we have several specific comments:

Under the listing of essential elements of an ACO, the discussion draft calls for the use of "community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations." As you work to expand and clarify this concept, we encourage you to avoid mandatory contracting requirements or "any willing provider" provisions that require specific provider types or facility settings. We believe this language should focus instead on incentivizing ACOs to meet the underlying objective of providing outstanding access to care. Creating a flexible, goal-oriented provision will allow ACOs to meet this objective using innovative and responsive approaches to addressing diverse patient care needs.

The essential elements of an ACO reference the use of quality indicators. This is a critical component to a successful ACO and we encourage extensive development of this requirement. As a guiding principle, we recommend a focus on existing, well-established quality measures such as the Medicare five star rating, HEDIS or NCQA. These commonly used national data sets will allow the state to focus health care organizations on improving clinical and service quality without the distraction of developing and implementing new or unique measurement and reporting systems.

Also in the list of essential elements of an ACO is a reference to "strong safeguards for consumers." It is not clear what this phrase means in that context. Additional clarification would be helpful.

Part 1 -- Goals and Policies

Section 1(f) on page 1 references the collection of high quality information used to measure health outcomes, etc. Additional detail would be helpful here to better understand whether this means claims data or clinical quality data pulled from electronic medical record systems. Leveraging existing data collecting efforts, such as those led by the Oregon Health Care Quality Corporation, would allow the state to move quickly to build on existing efforts.

ORS 414.620 (2) on page 2 calls for payment reform. We strongly support a move toward global payments linked to patient-centered care and demonstrable quality outcomes. There are many examples of this shift across the country, including pilots underway in other states and recent changes to the Medicare Advantage program.

Part 2 -- Delivery System Changes

The list of essential ACO elements in this section includes a requirement that organizational structures include various specified representatives. In providing additional clarity on this requirement, we encourage a flexible, rather than prescriptive, approach to demonstrating that the ACO is working effectively to reduce health disparities and increase health equity by incorporating diverse views and perspectives into its organizational decision-making.

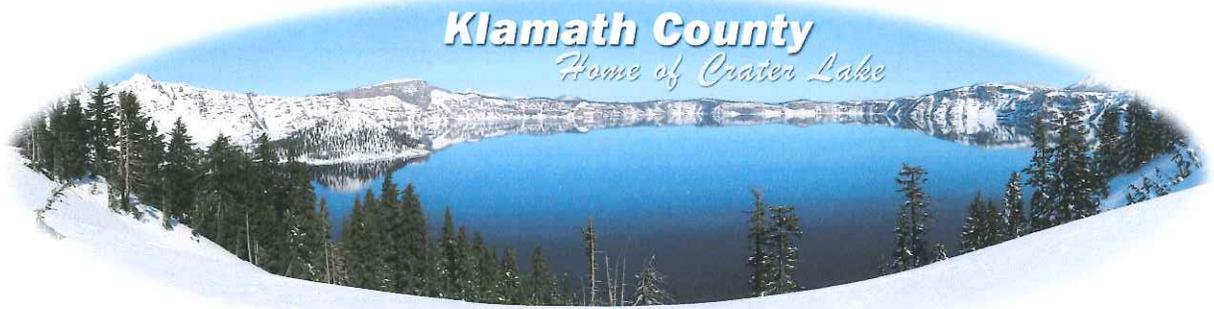
Part 3 -- Related Implementation Recommendations

As noted by at least one other commenter, we share the concern that much of the Transformation Team's concept will be dependent on federal waivers. Additional direct engagement by, and clarity from, federal officials would be helpful at this stage of the process.

Thank you again for the opportunity to comment on this draft. We look forward to working closely with the OHA staff and the Transformation Team as this important work moves forward.

Daniel J. Field
Director, Community Benefit & External Affairs
Kaiser Foundation Health Plan of the Northwest
Tel: 503.813.2467 Email: Daniel.J.Field@kp.org

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Klamath County Commissioners

Al Switzer, *Commissioner*
Position One

Dennis Linthicum, *Commissioner*
Position Two

Cheryl Hukill, *Commissioner*
Position Three

March 8, 2011

The Honorable John Kitzhaber
900 Court St NE
Salem OR 97301

RE: Health System Transformation Team

Dear Governor Kitzhaber:

Thank you for the opportunity to provide feedback regarding the Health System Transformation Team's legislative concept. The Association of Oregon Counties supports the team's goals and discussions on local provision of physical and mental health care. Since counties serve as the mental health and public health authorities, any issue surrounding provision of mental and public health services are of great importance to us.

The legislative concept as recently proposed outlines the responsibilities of newly formed accountable care organizations that will provide "integrated physical health, dental, mental health, chemical dependency, home and community based, and long term care and support services." Additionally, an "essential element" of these accountable care organizations is to "work cooperatively with community partners to address public health issues."

In our role as mental health and public health authorities, it is imperative that county commissioners be involved in taking a more active role that would, at a minimum, include forming Requests for Proposals and designating accountable care organizations. Additionally, as elected officials who are closest to our constituents who experience mental and physical illness, we are held accountable by the public for these services. Millions of dollars in county general funds statewide are appropriated annually to support community mental health and public health services.

Health System Transformation Team pg1

305 Main Street, Klamath Falls, Oregon 97601
Phone: (541) 883-5100 | Fax: (541) 883-5163 | Email: bocc@co.klamath.or.us



Klamath County Commissioners

Al Switzer, Commissioner
Position One

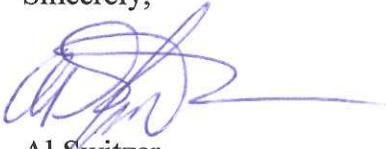
Dennis Linthicum, Commissioner
Position Two

Cheryl Hukill, Commissioner
Position Three

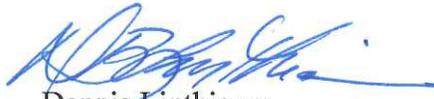
Discussions being held at the Health System Transformation Team will lead to delivery system changes that would significantly impact our county residents. It is crucial that county commissioners contribute directly to decisions affecting system for which we are held accountable.

We appreciate your consideration and look forward to discussing these issues further with you and your policy representatives.

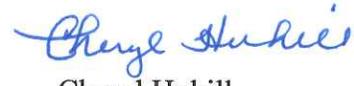
Sincerely,



Al Switzer,
Chairman



Dennis Linthicum,
Commissioner



Cheryl Hukill,
Commissioner

Health Systems Transformation Team
LEGISLATIVE CONCEPT
Preliminary Synopsis for Discussion Purposes

Primary Sources:

- Oregon Health Policy Board – Oregon’s Action Plan for Health (Dec. 2010)
- And reports of OHPB advisory groups
- Governor Kitzhaber’s Budget Report (January 2011)
- Meetings of the Health System Transformation Team

Assumptions:

- This LC does not make any changes to eligible populations or covered benefits.
- This LC uses the existing statutory framework in ORS Chapter 414 (Medical Assistance) to describe changes to statute appropriate for transformed delivery system that applies integrated health and services.

Key features of LC discussion draft:

Goals and policies for integrated health care and services

- Adopt the goals of improving the health of Oregonians, increasing quality, reliability and available of care, and reducing costs of care.
- Care and services are integrated and coordinated, including physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and support.
- Consumers get the care and services they need, coordinated locally with access to statewide resources when needed.
- People are at the center of coordinated care and services delivered through accountable care organizations using alternative payment methodologies that shift the focus to prevention, [healthy development of children and youth](#), improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care.
- [Health care systems should participate meaningfully in efforts to address drivers of the need for health care and ill health in their communities](#)

An accountable care organization is a single integrated organization that accepts responsibility for the cost within its global budget and for delivery, management and quality of the full continuum of care delivered to the specific population enrolled with the ACO. Essential elements of an ACO include (summarized);

(a) Work cooperatively with community partners to address public health issues [and policy development in community settings related to chronic disease and injury prevention. The extent of participation should be substantial but commensurate with the burden of those public health issues on the specific population enrolled in the ACO;](#)

Health Systems Transformation Team
LEGISLATIVE CONCEPT
Preliminary Synopsis for Discussion Purposes

- (b) Health equity is prioritized and disparities are reduced;
- (c) Actively engages consumers in making its decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered;
- (d) Person-centered, providing integrated person-centered care and services designed to provide choice, independence and dignity [at critical ages across the life span](#);
- (e) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery, including comprehensive transitional care;
- (f) Local access to care [and prioritized outreach efforts](#), including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations, [supports for self-management of chronic diseases](#) and referral to community and social support services, with access to statewide resources when needed;
- (g) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate [and assures that public health surveillance can be performed with optimal accuracy and minimal reporting burden for providers](#);
- (h) Strong safeguards for consumers are established;
- (i) Prioritize working with ACO members with high needs and multiple chronic conditions, [developmental delays or conditions](#), mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, [educational](#), remedial and supportive care and services;
- (j) ACO providers work are educated about the integrated approach, emphasize preventive resources, [school and workplace wellness](#), healthy lifestyle choices and evidence-based practices, shared decision-making, and communication;
- (k) Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual's needs as a whole person, and work with the individual [and their family](#) to develop an individual care and service plan;
- (l) Quality indicators are used; and
- (m) Demonstrate excellence of operations.
- [\(n\) ACO workplace wellness activities model for other organizations the importance of this issue and help ensure that ACO staff practice what they preach.](#)

Related implementation changes and key definitions

Use of information and confidentiality

Cooperation & delegation authority between OHA and DHS

Grant authority for demonstration on integrated services for individuals who are dually eligible

Authority to seek federal approvals

NOTE: This LC does not attempt to identify all possible conforming amendments, pending review and comment on the LC.

GOALS AND POLICIES

AMEND current law with updated goals and findings

GENERAL PROVISIONS

414.018 Goals; findings. (1) It is the intention of the Legislative Assembly to achieve the goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians; and lowering or containing the cost of care so it is affordable for everyone.

(2) The Legislative Assembly finds:

(a) A significant level of public and private funds is expended each year for the provision of health care to Oregonians;

(b) The state has a strong interest in assisting Oregon businesses and individuals to obtain reasonably available insurance or other coverage of the costs of necessary basic health care services;

(c) The lack of basic health care coverage is detrimental not only to the health of individuals lacking coverage, but also to the public welfare and the state's need to encourage employment growth and economic development, and the lack results in substantial expenditures for emergency and remedial health care for all purchasers of health care including the state; and

(d) The use of integrated health care and services systems has significant potential to reduce the growth of health care costs incurred by the people of this state;

(e) Attention to the drivers of ill health and the need for health care is essential for effective reduction of health care costs, especially in the long term.

(f) Preventing illness and injury and supporting wellness saves money, improves productivity and maximizes the potential of all Oregonians.

(g) Protecting the health of Oregonians requires integrating human health concerns into natural and built environment policies and programs.

(h) Special attention should be paid to protecting the health of the most vulnerable Oregonians, such as young children, the elderly, those with compromised immune systems and pregnant women.

(3) The Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability and availability of care, and reducing costs requires an accountable and integrated health system:

(a) All health care and services are coordinated, including physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and support;

(b) Including long term care supports and services in the transformed health system promotes and encourages greater utilization of home and community based services, with nursing facility care used primarily for transition services;

Deleted: .

(c) Services for Oregonians who are fully eligible for both Medicare and Medicaid are included within the transformed health system;

(d) People are at the center of coordinated care and services delivered through accountable coordinated care contracts using alternative payment methodologies that shift the focus to prevention, [healthy child and youth development](#), improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care;

(e) Communities and regions are accountable for improving the health of their communities, reducing avoidable health gaps among different cultural groups and managing health care and service resources;

(f) [The health system must be substantially engaged in preventing chronic diseases and injuries and assuring healthy child and youth development in their enrolled population, and contribute to prevention efforts that extend into a wider population](#), and

(f) High quality information is collected and used to measure health outcomes, [risk factors and trends](#), [health care](#) quality, costs, and clinical health information.

AMEND current law with updated legislative intent (from OHPB Report p. 5)

OREGON ACCOUNTABLE HEALTH CARE AND SERVICES SYSTEM

414.610 Legislative intent. It is the intent of the Legislative Assembly to develop and implement new strategies to achieve an accountable and integrated system that improves health, increases the quality, reliability and availability of care, and reduces costs by creating a system in which:

(1) Consumers to get the care and services they need, coordinated locally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language;

(2) Consumers, providers, community leaders and policymakers have the high-quality information [and public health surveillance data](#) they need to make better decisions and keep delivery systems accountable;

(3) Quality and consistency of care are improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume;

(4) Communities and health systems work together to [address the major drivers of the need for health care, especially chronic diseases and injuries, and early childhood development](#), and to find innovative solutions to reduce overall spending, increase access to care and improve health; and

(5) Electronic health information is available when and where it is needed to [support public health surveillance](#) improve health and health care through a secure, confidential health information exchange.

414.620 System established.

(1) There is established the Oregon Accountable Health Care and Services System. The system shall consist of state policies and actions that make integrated care and services organizations

accountable for care management and the provision of integrated health care and services for eligible persons, managed within a fixed budget by providing care better so that efficiency and quality improvements address medical inflation and the major drivers of the need for health care, especially those related to chronic diseases and injuries and early childhood development, and take these actions in a way that supports development of regional accountability for health, while maintaining the regulatory controls necessary to assure quality and affordable health services to all Oregonians.

Deleted: , to the extent possible, caseload growth

(2) The Accountable Health Care and Services System should pay for quality while managing within a global budget. The system should hold accountable care organizations and their providers responsible for the quality and efficiency of care they provide, reward good performance and keep total spending to a global budget that limits cost increases. Within the health care system, restructured payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered primary care homes, the provision of community-based supports for healthy child and youth development, self-management of chronic diseases, engagement with community partners in policy development that addresses the factors that cause ill health and create the need for health care,

Deleted:

(3) Alternative payment methodologies or methods will be used, that move from predominantly fee-for-service to alternate payment methods, in order to base reimbursement on quality and preventive efficacy rather than volume of services.

DELIVERY SYSTEM CHANGES

AMEND existing statute to describe procurement and requirements for accountable care organizations

414.725 Accountable care organization contracts; financial reporting; rules. (1)(a) Pursuant to rules adopted by the Oregon Health Authority, the authority shall execute accountable care organization contracts for integrated health care and services funded by the Legislative Assembly. The contract must require that all health services defined in ORS 414.705(2) are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the authority shall establish timelines for executing the contracts described in this paragraph.

(b) It is the intent of ORS 414.705 to 414.750 that the Oregon Health Authority use, to the greatest extent possible, accountable care organizations receiving global payments to provide integrated physical health, dental, mental health, chemical dependency, home and community based, and long term care and support services under ORS 414.705 to 414.750.

(c) The authority shall solicit qualified providers or plans that meet the standards established in ORS 414.xxx [see new statute below] to be reimbursed for providing the integrated covered services as part of an accountable and coordinated health system. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans, county health departments and any other qualified public or private organization that meet the qualifications for an accountable care organization. After contracts are awarded pursuant to this section, the authority may negotiate with any successful proposal respondent

for the expansion or contraction of service areas if there are potential gaps or duplications in service areas.

(d) The authority shall establish annual financial reporting requirements for accountable care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each accountable care organization and that includes information on the three highest executive salary and benefit packages of each accountable care organization.

(e) The authority shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with an accountable care organization.

(f) (A) The authority shall adopt rules and procedures to ensure that a rural health clinic that provides a health service to an enrollee of an accountable care organization receives total aggregate payments from the organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

Comment [S1]: Why this carve out for rural clinics? Should local health departments have similar protection?

(B) "Rural health clinic," as used in this paragraph, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority may contract for alternative innovative integrated health and services arrangements for the delivery of integrated services for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state as long as the alternative innovative arrangement meets the essential qualifications in ORS 414.xxx. For purposes of this chapter, a reference to a qualified entity providing integrated services under contract with the authority pursuant to this subsection shall be a reference to an accountable care organization, to the extent the Oregon Health Authority determines appropriate.

(3) As provided in subsections (1) and (2) of this section, the aggregate expenditures by the authority for integrated services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for integrated services under ORS 414.705 to 414.750.

(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide integrated services shall be performed pursuant to state supervision and shall be considered to be conducted at the direction of this state, shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

(5) Health care providers contracting with accountable care organizations to provide services under ORS 414.705 to 414.750 shall advise an ACO member of any service, treatment or test that is medically necessary or that could slow progression of loss of function but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) An accountable care organization shall provide information on contacting available providers to an ACO member in writing within 30 days of assignment to the accountable care organization.

(7) Each accountable care organization shall provide upon the request of an enrollee or prospective enrollee annual summaries of the organization's aggregate data regarding:

- (a) Grievances and appeals; and
- (b) Availability and accessibility of services provided to enrollees.
- (8) An accountable care organization may not limit enrollment in a designated area based on the zip code of an enrollee or prospective enrollee.

NEW STATUTE to adopt “ESSENTIAL ELEMENTS” integration and

ORS 414.xxx Essential elements for accountable care organization care system shall, at a minimum, have or obtain through contractual arrangement, the following functional capacities in accordance with the standards and contracts established by the Oregon Health Authority:

(1) Accountable care organizations improve the quality of care, lower cost, and improve health and well-being of their members.

(a) The organization is accountable for the overall health of children and adult members in their area, and for working cooperatively with community partners to address public health issues that affect the health of the community, including policy development in community settings related to chronic disease and injury prevention and healthy child and youth development. The extent of participation should be substantial but commensurate with the burden of those public health issues on the specific population enrolled with the ACO;

(b) Health equity is prioritized and disparities are reduced. ACO organizational structures must include ethnically diverse populations in the community, consumers including seniors, people with disabilities and people using mental health services, and ensure that ACO decision-making reflects the views of providers in the ACO network.

(c) The organization actively engages consumers in making its decisions that impact the populations served, the communities where it is located, and decisions about how integrated care is delivered.

(2) Accountable care organizations are person-centered organizations that provide integrated person-centered care and services designed to provide choice, independence and dignity:

(a) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery that address preventive, supportive and therapeutic needs of the individual in a holistic fashion, using person-centered primary care homes chronic disease self-management supports in the community, and individual care plans to the extent feasible, and that provides assistance in navigating the system if needed;

(b) Individuals receive comprehensive transitional care, including appropriate follow-up, when entering and leaving inpatient hospital or nursing facility to other care settings or return to their home;

(c) Access to services and supports are geographically located as close to home as possible, including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations, and referral to community and social support services, with access to statewide resources when needed;

(d) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate and also supports public health surveillance; and

(e) Strong safeguards for consumers are established, including safeguards against underutilization of services and protections against inappropriate denials of services or

treatments in connection with utilization of alternative payment methods or transition to a global payment system.

(3) Accountable care organizations prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services, and reducing the use of services provided in emergency rooms and hospital readmissions.

(4) The accountable care organization's providers work together to develop best practices for care and service delivery to reduce waste and improve the health and well-being of individuals:

(a) Providers are educated about the integrated approach, and how to access and communicate within the integrated system about an individual's plan and health history.

(b) Providers emphasize preventive resources, healthy lifestyle choices and evidence-based practices, shared decision-making, and communication.

(c) Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual's needs as a whole person, and work with the individual to develop an individual care and service plan

(d) Providers maximize use of electronic health records to assure continuity of care across the service delivery system.

(e) ACO workplace wellness activities model for other organizations the importance of this issue and help ensure that ACO staff practice what they preach.

(5) Quality indicators are evaluated to assess ongoing health status of individuals, including demographic and diversity data, consistent with standard quality measures adopted by and timely reported to the Oregon Health Authority to evaluate costs, experience of care, and population health and risk factors for the major drivers of the need for health care, especially chronic diseases and injuries and early childhood development.

(6) Accountable care organizations demonstrate excellence of operations, including best practices in financial management capabilities, including but not limited to the management of claims processing and payment functions for ACO providers, and contract management capabilities, including but not limited to network provider creation and management functions, as well as workplace wellness activities that model best practices in disease prevention.

NEW – Language for the service delivery expectations for individuals who are dually eligible – 414.xxx Conditions for coverage for certain individuals who are dually eligible for Medicare and Medicaid

(1) Accountable care organizations that meet the standards established in ORS 414.xxx [above] are responsible for providing Medicare and Medicaid services to individuals who are dually eligible, including obtaining any necessary authorization from Medicare.

(2) Care and services for individuals who are dually eligible must emphasize preventive services, and services supporting independence and continued residence at home or in their community. Services for individuals who are dually eligible must be person-centered, and provide choice, independence and dignity reflected in individual plans and assistance with accessing care and services.

(3) The Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services to seek approval of contracting procedures and blended reimbursement methods for accountable care organizations responsible for enrolled individuals who are dually eligible.

AMEND Current statute for patient-centered primary care home services –

414.760 Person centered primary care home services.

(1) The Oregon Health Authority shall establish standards for implementation and utilization of person centered primary care homes and encourage their use in contracts with accountable care organizations. If practicable, efforts to align financial incentives to support person centered primary care homes for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in ORS 442.210 (3)(d).

(2) Each accountable care organization shall implement, to the maximum extent feasible, person centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations. The organization shall require its other health and services providers to communicate with the primary care home in a timely manner and participate in care coordination including use of electronic health information technology. The authority may reimburse person centered primary care homes for interpretive services provided to people in the state's medical assistance programs if interpretive services qualify for federal financial participation.

(3) The authority shall require person centered primary care homes receiving these reimbursements to report on quality measures described in ORS 442.210 (1)(c).

(4) The Authority shall also establish standards for community-based supports for self-management of chronic diseases, child and youth development and care coordination, community-based chronic disease and injury prevention activities, school and worksite wellness programs and public health surveillance that could be used in contracts with ACOs. These standards shall be based on best practices documented in the research literature or in widespread use.

Comment [S2]: Not sure if this belongs in this section or needs its own 414.xxx.

RELATED IMPLEMENTATION RECOMMENDATIONS

NEW STATUTE for coordination and delegation of authority between DHS and OHA for implementation

(1) The Department of Human Services and the Oregon Health Authority shall cooperate with each other by coordinating actions and responsibilities necessary to implement an accountable and integrated health and service delivery system in accordance with this 2011 Act, in a manner consistent with the responsibilities of the authority for the medical assistance program pursuant to ORS 413.032.

(2) The department and the authority may delegate to each other any duties, functions or powers that the department or the authority deem necessary for the efficient and effective operation of their respective functions for purposes of this 2011 Act.

NEW STATUTE for use of information sharing and confidentiality

414.xxx Disclosure and use of medical assistance records by ACOs limited; contents as privileged communication; exceptions.

(1) A hallmark of integrated accountable care organizations' effective management and service delivery is the appropriate use of ACO member information which includes use of electronic health information and administrative data that is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.

(2) ACO members must have access to their personal health information, in the manner provided in 45 CFR 164.524, so they can share it with others involved in their care and make better health care and lifestyle choices.

(3) An accountable care organization and its provider network shall use and disclose ACO member information for purposes of service and care delivery, coordination, service planning, transitional services, reimbursement, and the requirements of this chapter, in order to improve the safety and quality of care, lower the cost, and improve health and well-being of their members. Integrated whole-person care necessarily requires access to and use of information about all aspects of the person's health and mental health condition, and sensitive diagnosis information including HIV and other health and mental health diagnoses, within the accountable care organization. Such uses and disclosures by the accountable care organization and its providers for purposes of providing integrated health care and services is required by law in accordance with this section. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.518 to 192.526 and applicable federal privacy requirements, and redisclosures outside of the accountable care organization and its providers for purposes unrelated to this section or the requirements of this chapter remain subject to any applicable state privacy requirements.

Comment [S3]: As I read it there is nothing in this section that limits the special public health authorities included in HIPAA, but just want to be sure.

(4) For the protection of ACO members, except as otherwise provided in this section, an accountable care organization and its providers shall not disclose or use the contents of any records, files, papers or communications for purposes other than those directly connected with the administration of the ACO and the public assistance laws of Oregon, or as necessary to assist the ACO members in accessing and receiving other governmental or private nonprofit services, and for public health activities as provided in law, and these records, files, papers and communications are considered confidential subject to the rules and regulations of the Oregon Health Authority. In any judicial or administrative proceeding, except proceedings directly connected with the administration of public assistance or child support enforcement laws, their contents are considered privileged communications.

(5) Nothing in this section prohibits disclosure of information between the ACO and its provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the public assistance or public health laws of Oregon.

AMEND – This is the state mini-HIPAA privacy law; need to amend to address privacy issues 192.519 Definitions for ORS 192.518 to 192.529. As used in ORS 192.518 to 192.529:

(2) “Covered entity” means:

(a) A state health plan;

(b) A health insurer;

(c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.518 to 192.529; or

(d) A health care clearinghouse.

(e) An accountable care organization contracted with the Oregon Health Authority

AMEND current statute related to grant authority for demonstration on integrated services for individuals who are dually eligible

414.033 Expenditures for medical assistance authorized. The Oregon Health Authority may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare and public health purposes, including, but not limited to, any project which determines the cost of providing medical assistance to individuals who are dually eligible or to evaluates service delivery systems or to describe trends in disease incidence, prevalence and risk factors in this population.

NEW STATUTE Necessary federal approvals may be requested

(1) To promote the adoption of alternative payment methodologies and contracting with ACOs, the Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services for any approval necessary to obtain federal financial participation in the costs of activities described in this 2011 Act, including but not limited to:

(a) Seeking federal approvals necessary to permit Medicare to participate in Oregon's alternative payment and integrated service methodologies. Upon obtaining federal approval for Medicare participation, such participation shall be commenced and continued and the authority shall seek extensions or additional approvals, as necessary.

(b) Seeking federal approvals necessary to support the transition to and implementation of global and alternative payment systems, and formation and utilization of ACOs in the medical assistance program.

(c) Seeking federal approvals to use Medicaid or Medicare funding streams for population health or public health services

(2) The authority shall adopt rules implementing the provisions of this 2011 Act requiring federal approval as soon as practicable after receipt of the necessary federal approval and may provide for implementation in stages in accordance with the availability of funding.

(3) Sections of this 2011 Act requiring federal approvals become operative on the later of _____, or the date on which the Oregon Health Authority receives any federal approval required to secure federal financial participation under subsection (1) of this section.

KEY DEFINITIONS

AMEND current statute defining "medical assistance"

414.025 Definitions. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

*** [NO CHANGES IN POPULATIONS COVERED OR DEFINITIONS OF "INCOME" OR "INVESTMENTS AND SAVINGS]

(5) "Medical assistance" is synonymous with "integrated health care and services" or "integrated services", which means so much of the following preventive, medical, remedial and supportive care and services as may be funded by the Legislative Assembly and prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032,

including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

- (a) Inpatient hospital services, other than services in an institution for mental diseases;
 - (b) Outpatient hospital services;
 - (c) Other laboratory and X-ray services;
 - (d) Skilled nursing facility services, other than services in an institution for mental diseases, and other long term care services and supports;
 - (e) Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere;
 - (f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;
 - (g) Home health care services;
 - (h) Private duty nursing services;
 - (i) Clinic services;
 - (j) Dental services;
 - (k) Physical therapy and related services;
 - (L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;
 - (m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;
 - (n) Other diagnostic, screening, preventive and rehabilitative services;
 - (o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;
 - (p) Any other medical care, and any other type of remedial care recognized under state law;
 - (q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;
 - (r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases;
 - (s) Hospice services;
 - (t) Home and community based services;
 - (u) Mental health services; and
 - (v) Chemical dependency services.
 - (w) Community-based preventive services, including policy development to address major drivers of the need for health care, especially chronic diseases and injuries.
 - (x) Public health surveillance activities
- (6) "Medical assistance" includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. "Medical assistance" includes "health services" as defined in ORS 414.705. "Medical assistance" does not include care or services for an inmate in a nonmedical public institution.

(7) [OMIT DEFINITION OF MEDICALLY NEEDY – NOT CHANGED; COULD BE REPEALED, SINCE NO MEDICALLY NEEDY PROGRAM AT THIS TIME]

(8) [OMIT DEFINITION OF RESOURCES – NOT CHANGED]

(9) “Individual who is dually eligible” means an individual who is entitled to, or enrolled for, benefits under Part A of Title XVIII, or enrolled for benefits under Part B of Title XVIII, and is eligible for medical assistance under Title XIX of the Social Security Act in accordance with this chapter.

(10) “Person-centered primary care home” means a primary care team or clinic which is organized in accordance with standards as defined by the Oregon Health Authority and which incorporates the following core attributes:

- (a) Access to care;
- (b) Accountability;
- (c) Comprehensive whole person care;
- (d) Continuity;
- (e) Coordination and integration; and
- (f) Person and family centered care.

(10) “Accountable care organization” or “ACO” means a single integrated organization that accepts responsibility for the cost within its global budget and for delivery, management and quality of care delivered to the specific population of patients enrolled with the ACO; which operates consistent with the principles of a person-centered primary care home and satisfies the other requirements of this chapter; which has a formal legal structure to receive global payments and distribute payments and savings; and which complies with any federal requirements applicable to ACOs, however named. An ACO may include an alternative innovative integrated health and services arrangement approved by the authority in accordance with ORS 414.725.

(11) “ACO member” means an individual who receives integrated medical, remedial and supportive care and services through an accountable care organization.

(12) “Alternative payment methodologies or methods” means methods of payment that are not fee-for-service based and that are used by ACOs to compensate their providers for the provision of integrated health care and services, including but not limited to shared savings arrangements, bundled payments, episode-based payments, and global payments, as defined by rules adopted by the Oregon Health Authority. No payment based on the fee-for-service methodology shall be considered an alternative payment.

(13) “Quality measures” means objective benchmarks established in accordance with nationally accepted performance metrics and as otherwise permitted under this chapter for assessing provider and ACO performance.

Comment [S4]: Might need definitions of public health surveillance, policy development, community-based self-management supports, county health departments, chronic diseases, injuries

AMEND current statute to define “integrated health care and services”

414.705 Definitions for ORS 414.705 to 414.750.

(1) As used in ORS 414.705 to 414.750, “integrated health care and services” or “integrated services” means at least so much of medical assistance as defined in ORS 414.025, including health services, as may be prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032 and that are approved and funded by the Legislative Assembly.

(2) “Health services” means so much of the following care and services funded by the Legislative Assembly in accordance with the prioritized list of health services under ORS 414.720:

- (a) Services required by federal law to be included in the state’s medical assistance program in order for the program to qualify for federal funds;
- (b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner’s practice as defined by state law, and ambulance services;
- (c) Prescription drugs;
- (d) Laboratory and X-ray services;
- (e) Medical supplies;
- (f) Mental health services;
- (g) Chemical dependency services;
- (h) Emergency dental services;
- (i) Nonemergency dental services;
- (j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state’s medical assistance program;
- (k) Emergency hospital services;
- (L) Outpatient hospital services; and
- (m) Inpatient hospital services.
- (n) Community-based supports for self-management of chronic diseases
- (o) Community-based chronic disease and injury prevention activities and
- (p) Public health surveillance



Lake County Board of Commissioners

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Dan Shoun, Chairman
Bradley J. Winters, Vice-Chairman
Ken Kestner, Commissioner

March 8, 2011

The Honorable John Kitzhaber
900 Court St., NE
Salem, OR 97301

RE: Health System Transformation Team

Dear Governor Kitzhaber:

This Board of Lake County Commissioners has recently been made aware of the Legislative Concept put together by the Health System Transformation Team. As the designated Local Authority for our mental health program and public health program at the county-level, we are always supportive of investigating options for enhancing the services to our citizens.

When changes are being proposed that affect the delivery of services to our county citizens, as being considered by the Transformation Team, this Board duly requests, and considers it crucial, that local County Commissioners be directly involved in formulating those changes. Thank you for your consideration to this matter. We look forward to being partners with you and your staff.

Sincerely,

Dan Shoun

Bradley J. Winters

Ken Kestner

CC: Tina Edlund; tina.d.edlund@state.or.us
Bruce Goldberg; bruce.goldberg@state.or.us
Mike Bonetto; mike.bonetto@state.or.us

From: "Charles Maclean" <advocate@philanthropynow.com>
To: "Oregon Health Policy Board" <ohpb.info@state.or.us>
Date: 3/8/2011 12:47 PM
Subject: Input #2 to Legislative Concept

Input to Oregon Health Systems Transformation Team

Legislative Concept
NEW STATUTE to adopt "ESSENTIAL ELEMENTS"
ORS 414.XXX
Insert in Section (2f)

Decisions and expenditures for all aspects of care must be driven by documented benefits for the patient. The goal is to assure patient safety, reduce unnecessary costs and eliminate treatments and interventions that do harm or result in little documented good or which can lead to disease causing stress.

These treatment and reimbursement decision making principles will be rigorously applied to all surgical and nonsurgical procedures, pharmaceutical interventions, laboratory work and diagnostic technologies. Provisions for monitoring and oversight will be enacted by non-commercial experts appointed by appropriate public interest bodies who have no economic interests in the decisions.

Safeguards will be put in place to prevent "marketplace created non-diseases", unsubstantiated preconditions and artificially manipulated medical markers driven by financial gain rather than by health efficacy and cost worthiness.

Submitted by Charles B. Maclean, PhD - Senior Health Care Fellow and Rose Winters, Executive Director - the Gladys McGarey Medical Foundation. Contact Information: advocate@philanthropynow.com 503.297.1490 and rosewinters@cox.net (602) 502-2234

Version 1.0 March 8, 2011



Oregon Association of Area Agencies on Aging & Disabilities

March 8, 2011

Tina Edlund
Deputy Director for Planning and Policy Implementation
Oregon Health Authority

Dear Ms. Edlund,

Thank you for the opportunity to provide input on the proposed Legislative Concept currently being reviewed by the Health System Transformation Team. Briefly, here are my initial comments on the draft language.

Part 1 - Goals and Policies

This section mentions "global" budgets several times. The definition of global could be interpreted several ways. For example, the current long term care system is operated under a statewide system which could be considered global in nature. Under this system consumers, no matter where they live, are assessed using a standard tool that is highly developed. Long term care benefits are determined and authorized using this standardized, detailed and prescriptive tool. Funding and payments for long term care services are managed state-wide. Under this type of managed system using a standardized assessment tool and global budget, Oregon has achieved much recognition as having a very cost effective and extremely successful long term care system.

Part 2 - Delivery System Changes

During our HSTT meetings it has been repeatedly stated that the system is broken and there is a severe problem with out of control health care costs. Conversely, there has been recognition that the model of long term care currently in place has been exceptionally efficient and effective over several decades. As stated above, this model is indeed a very successful "managed" model. However, the proposed Legislative Concept language moves long term care away from its successful social model into a medical model which clearly is having problems. This is not the right direction.

Provision of human services for seniors and people with disabilities in long term care programs should not be housed under medical managed care organizations. Rather, the best care would be provided by a mandatory coordination (as opposed to full integration) between a social long term care case manager and a member of the individual's medical primary care home or managed care organization.

Thank you,

Kay Metzger, Chair
Oregon Association of Area Agencies on Aging and Disabilities



Health System Transformation Team Legislative Concept

Proposed Revisions

Reproductive health must be **explicitly listed** as necessary for integration along with (physical health, mental health, addictions treatment, oral health, home and community based services and long term care services and support) or the fragmentation that currently exists between primary care and reproductive health will be propagated under this new system.

- Women spend on average 30 years trying not to become pregnant.
- 48% of pregnancies in Oregon are unintended.
- Approximately 70% of women who had an unintended pregnancy gave reasons that demonstrated they lacked comprehensive contraception advice from a clinician.

Over the last 20 years reproductive health has been siloed and separated from women's primary health care. It has been assumed in statute that physical care/primary care includes reproductive health care, but in practice it has been excluded. The delivery system most often does not recognize reproductive health as an essential service to be integrated into primary care.

However, the **ongoing need for reproductive health** has many of the characteristics of a chronic health condition requiring frequent monitoring and oversight by primary care. The current reimbursement system recognizes and rewards family planning only providers. Family planning services are only reimbursed when it is a separate service from primary care.

Therefore, we respectfully ask the Oregon Health Policy Board to **explicitly list** reproductive health as necessary for integration along with these other services.

Below you will find our recommended changes to the Health System Transformation Team's Legislative Concept. Please see additions in **bold**.

Key features of LC discussion draft: Goals and policies for integrated health care and services **2nd Bullet:** "Care and services are integrated and coordinated, including physical health, mental health, **REPRODUCTIVE HEALTH**, addictions treatment, oral health, home and community based services, and long term care services and support."

Under the statutory amendment **414.725 (b)**: “It is the intent of ORS 414.705 to 414.750 that the Oregon Health Authority use, to the greatest extent possible, accountable care organizations receiving global payments to provide integrated physical health, dental, mental health, **REPRODUCTIVE HEALTH**, chemical dependency, home and community based, and long term care and support services under ORS 414.705 to 414.750.”

Under the statutory amendment **414.018 Goals; Findings (3) (a)**: “All health care and services are coordinated, including physical health, mental health, **REPRODUCTIVE HEALTH**, addictions treatment, oral health, home and community based services, and long term care and support.”

Please contact the Oregon Foundation for Reproductive Health with any questions:

Michele Stranger Hunter, Executive Director
(503) 223-4510
Michele@prochoiceoregon.org



March 8, 2011

To: Health Transformation Committee staff
Fr: Chris Bouneff, NAMI Oregon executive director
Re: Legislative Concept feedback

NAMI Oregon wishes to express its preliminary support for the legislative concept presented to the Health System Transformation Committee on March 2, 2011. Given the short timeframe for analysis and contemplation, we can only offer a couple of specifics at this point in the process, although we look forward to being engaged in ongoing discussions about how mental health and addiction treatment and support services are integrated into a new health care system. Certainly, there are many details to work out, which we hope are done in the same collaborative and public manner as current discussions.

We recommend:

- **More specific language on regionalization.** The new Accountable Care Organizations should generally serve contiguous communities, which will help generate the economies of scale needed to broaden the array of covered services available in a given region. Our experience with Mental Health Organizations serving Oregon Health Plan patients demonstrates that problems arise when service areas aren't logically formed.
- **More consumer involvement in actual governance.** The current concept calls for active engagement of consumers in making decisions. However, we believe that any proposed legislation also should require consumer involvement in an ACO's actual governance and that "governance" be inserted in language. This may alleviate a common consumer complaint — that MCOs and MHOs are happy to have consumers serve in advisory roles, but, in practice, the consumer voice isn't a full participant in the governance structures that actually make decisions.
- **More financial and governance transparency.** Proposed legislation should be more specific as to financial reporting. Currently, the only statutory proposal is that ACOs report compensation for the three highest executives. NAMI favors a system more stringent for entities entrusted with public dollars and public health. An example to pull from is the new Form 990 for nonprofit entities with 501(c)3 status that provides a public report on finances, governance, board compensation, and conflicts of interest. We believe that statute should spell out these four domains in addition to compensation.

Moreover, statute should spell out that financial reporting must be more detailed. In 414.725(d), it currently reads, "The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each care organization..." Financial health, in insurance terms, revolves more around

ability to pay claims and solvency. However, it does not provide for accountability of spending Medicaid dollars. Statute should explicitly state that financial transparency includes reporting that demonstrates maximum use of each Medicaid dollar for direct health care and support services.

• **Specific inclusion of “public and private school systems” in language describing community partners with which an ACO must work.** In the children’s mental health system, interaction with and participation of school systems is vital to a child’s and family’s success. However, schools are often overlooked or decline to participate in a productive manner. We believe inclusion of school systems as an example removes any ambiguity with their status as a community partner in our health care system.

We also enclose with our comments NAMI Oregon’s recent policy statement on integration and regionalization. This gives some context to our suggestions above. And we hope that our policy statement is considered during the final drafting of a legislative concept.

Thank you for this opportunity to provide input.

NAMI Oregon Supports Smart Approaches to Health Care Reform

Integration of Mental Health and Physical Health

Adults with serious mental illness are dying 25 years earlier than other adults, largely of treatable medical conditions. Despite the fact that half of all serious mental illness occurs by age 14 and three-quarters by age 24, there is an average delay of nearly a decade before people get help for their symptoms.

➔ NAMI Oregon continues to favor integration of mental health and physical health services and the regionalization of services and administrative structures.

NAMI is following and participating in current discussions about integration in the context of the Triple Aim Objectives — better health, better care, and lower cost in a newly designed Medicaid system. Thus far, those discussions are encouraging.

However, NAMI will continue to guard against stuffing mental health treatment and support services into a medical model. In general, NAMI favors the “medical home” model in which a case manager or other accountable person monitors the total health of an individual living with mental illness and can help direct an individual or family to appropriate resources.

The experiences of state Medicaid systems in other states suggest that, without appropriate structures and protections in managed care arrangements, the quality and availability of services and supports for children and adult living with mental illness are often severely compromised.

➔ NAMI Oregon supports the goals of integrated care and urges a system with:

- Financial incentives for achieving desired outcomes.
- Reimbursement for case management services and incentives for “medical home” and “health home” models of care delivery.
- Contractual language that protects enrollees.
- Independent oversight structure with stakeholder involvement.
- Provision of non-medical services and supports for children and adults with serious mental health needs and their families.

Comments from ODS
on the
Legislative Concept
From the
Health Systems Transformation Team

March 8, 2011

The major design elements laid out in the narrative and proposed legislation are aspirational: A conceptual and theoretical framework for an ideal health system.

1. The problem is that no such system(s) currently exists, and the foundational structures on which such an ideal can be built are infantile and subject to significant risk in accepting the moral, health and financial accountabilities envisioned.
2. Realizing that a crisis is upon the State of Oregon, fast action is desirous, but the State must be prepared to manage a tumultuous environment in which everything may be changing simultaneously.
3. Will the State have in place a basic minimum framework from which to issue RFPs, objectively award contracts, and (most importantly) monitor contract performance using clinical, patient satisfaction, and financial criteria that are definable, measurable, and actionable by both parties to a contract?
4. To rationally bid on an RFP, entities must have comprehensive financial, utilization, and demographic data to assess the clinical and financial risks they are assuming. That means data on physical, mental health, dental, long-term care and other services by enrollment category and geographical region.
5. Oregon Health Plan (OHP) unit prices have always been substantially less than "market". The assumption behind the Accountable Care Organization (ACO) model is that there is sufficient waste, duplication and "frictional" expense in the current non-system of care that an amalgamation of physicians, dentists, mental health professionals and a wide array of institutions can, and will, "integrate" and, at worst, lose less than they do now, or, at best, make marginally more than now. Only a thorough and critical analysis of comprehensive historical data will permit a suitable evaluation of risk.
6. The State must develop contract performance standards that are more rigorous than anything they have used to date. It is understood by many that variations in treatment patterns exist in the current capitated, managed care organizations (e.g., DCOs). "Integration" and "evidence based care" are appropriate aspirations, but in getting there we must not forget that tens of thousands of beneficiaries must trust their ACO to deliver medically necessary care, at the right time, at the right place. It is all too easy under current contract performance standards to "short change" the patient to meet financial objectives.
7. The other side of the above situation (#7), is the honest and good faith implementation of clinical standards that are evidence-based, but that differ from the expectations of patients, their families and advocacy groups. What criteria and processes will the State use to differentiate unacceptable clinical behavior,

motivated by laziness or financial self-interest, from that which is clinically appropriate, but at odds with consumer expectations?

8. The State should also recognize the variability among providers of health care to reasonably assume financial risk within ACOs using alternative payment methodologies. Front-line providers of physical, mental and oral health are critical to timely access to quality care. These providers must also trust their ACO; the absence or erosion of trust will lead to collapsing local networks, contracted access and potential ACO implosion.
9. In conclusion: A) The vision and aspiration are directionally correct. B) The enemies of success include the speed of implementation necessitated by the current and continued State fiscal crisis, the lack of readiness of local health care "systems" to quickly adapt care delivery and financial systems to a subset of their patient populations, and the sea change necessary within State agencies to effectively and even-handily manage performance-based contracts of a complexity unknown to them.



March 5, 2011

Governor Kitzhaber and
The Health Systems Transformation Team
c/o Oregon Health Authority
Salem, OR 97301

Dear Governor Kitzhaber and Transformation Team members:

On behalf of all OPCA members, I would like to thank you for the time and effort you are investing in rethinking our health system. We share your commitment to an improved system and appreciate your recognition that the Safety Net has a critical role to play in this transformation process, as well as in the resulting system.

Below is our key feedback on the Legislative Concept distributed at the March 2, 2011 Transformation Team meeting. In addition, we attach an addendum which outlines detailed suggestions for modifications to the document with new language proposals in red. We would like to begin, however, by recognizing that this Legislative Concept for a transformed system includes elements of a social model of care rather than exclusively a medical model. We believe that to achieve the Triple Aim, we will need to fully embrace a social model of care, so we appreciate this effort as a first step on that journey.

1. ACO Boards and Board Decisions

Balance and Equity - We believe that the composition of ACO boards should be outlined in legislation, similar to that which was outlined for OHPB membership. As well, we believe that, at the very least, consumers, the safety-net, public health, and other social service entities must be represented on these boards and that fewer than half of board members should be employed by (or have family members employed by) the health care industry.

Transparency - Further, we recommend that decisions undertaken by these boards to redistribute system funds should be made transparent to the public

2. Alternative Payment Methodologies

Caution: Unintended Consequences - Any alternative payment methodology must be stratified to account for socioeconomic conditions. Without stratification or adjustments, we face the very real likelihood of increasing health disparities. As reported on in a 2010 JAMA article, health disparities are likely to increase under an alternative payment methodology for a reformed system of care if socioeconomic characteristics aren't taken into account (See "Relationship Between Patient Panel Characteristics and Primary Care Physician Clinical Performance Rankings" by Clemens S. Hong, Steven J. Atlas, Yuchiao Chang, et. al. Published September 8, 2010. Vol. 304, No.10).

3. Scope/Service Area of ACOs

Scope of Purpose - ACOs, as heretofore defined nationally, can vary widely in their scope/service area -- they have been discussed as agreements between two or more provider groups (e.g., a primary care

provider and specialists), between a hospital and several providers, or a number of any other configurations among health care providers. This Legislative Concept can be read (or misread) as though an ACO were more like a regional health organization – where broader communities and community groups are integrated and aligned to deliver health. We enthusiastically support this concept of broad accountability and integration, but believe that there is need for greater clarity in the document as to what exactly is meant.

Defining an ACOs Service Area - We believe it is important to clarify in statute the definition of an ACO service area versus a community versus the population served – and whether the population served by an ACO is the same as “population health” (as generally defined by public health professionals). We are concerned that without further clarification, confusion and disagreement will likely ensue.

4. Health vs Health Care?

We find that there is a mixing of these two concepts throughout the document. We believe that it should be clarified whether the ACO is accountable for health care or health of its population. We believe that it should be accountable for health. This issue becomes particularly pointed at the end of the document, when one reads the Key Definitions for “Integrated Health Care and Services.” Having already read the rest of the proposed Concept describing to some extent a social model of care, one then finds this Key Definition oddly exclusionary, as it outlines strictly a medical model.

Thank you again for this opportunity to provide input into your work. Please call me with any questions about our recommendations. We look forward to the revised Legislative Concept and to working with many of you on its implementation.

Best regards,

Craig Hostetler
Executive Director

Addendum

Recommendations for Language Changes to the Health Systems Transformation Team Legislative Concept

Respectfully Submitted for consideration by the
Oregon Primary Care Association

A. LC Section -- Goals and Policies

1. General Provisions

a. 414.018 Goals; findings

- (1) We suggest a melding of the new language and the old such as, "...to achieve the goals of **universally improving** lifelong health, increasing the quality..."

2. Oregon Accountable Health Care and Services Systems

a. 414.620 System established

- (1) We suggest the language be edited to read, "The system shall consist of ... and the provision of integrated health care and services for **the entire population within the ACO...**"
- (3) We suggest, "Alternative payment methodologies or methods will be used that... base reimbursement on:
 - a) **process and outcome indicators for access, quality, and cost metrics(including patient satisfaction) rather than volume of services; That is, value based payment.**
 - b) **include stratification for social and medical complexity, including substance abuse and mental health conditions, in these value based payments,**
 - c) **delivering the right care, beginning with appropriate primary care and prevention,**
 - d) **a payment glide-path that adjusts the current payment structure to reward defined work and providers that improve care: Because the transformation to a stable, sustainable ACO cannot happen overnight, reform should include incentives for the transformation journey as a bridge to value based payment.**
 - e) **shared risk and savings, as determined by a neutral third-party, to ensure that services are not diminished for the sake of the bottom line – including an equitable distribution of highly complex patients among providers within the ACO.**
 - f) **recognition that many safety-net clinics are paid differently for services than other providers. Because the structure for payment among Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) is unique, we urge the State to work directly with RHCs and FQHCs to develop a payment reform methodology that works for their particular characteristics.**

B. LC Section -- Delivery System Changes

1. Procurement and Requirements for ACOs

- a. 414.725 Accountable care organization, contracts; financial reporting; rules
 - (1)(c) It is not clear how the relationship between the state and an ACO will work since the description of an ACO (in the new statute language) indicates relationships among equal partners within a “community,” yet this section proposes to contract with individual providers or plans – rather than contracting with the ACO as a collective entity.
 - (3) We propose additional language for section 414.725 (3) as follows: “As provided in subsections...may not exceed the total dollars appropriated for integrated services under ORS 414.705 to 414.750, **but must include financial incentives and payment tied to population health outcome (such as overall reduction in regional smoking rates or reductions in the rate of X disease among populations within the service area experiencing health disparities).**”

2. Essential Elements - Integration and Accountability Standards

- b. 414.xxx Essential elements for accountable care organizations
 - (1)(a) We are concerned that the language in this section maintains the false working assumption that has created our current silo'd system -- that public health issues are distinct from the objective of an ACO rather than part of the continuum of health creation and maintenance. The language as written, “... and for working cooperatively with community partners...” implies that these partners are an add-on to the ACO. This is an example of what we reference above in suggestion 4 of the letter (Health vs Health Care?) and it leaves us uncertain about what the objective of the ACO is, as defined by this Legislative Concept. As noted above, we believe it should be about health and that the expectation should be that these entities – public health, social service, etc. - will be a part of each ACO.
 - (1)(b) We recommend adding, “...ACO organizational structures **and its board** must include...”
 - (1)(d) We would like to suggest that retaining the idea of “as feasible” makes this a hollow element.
 - (3) We recommend adding, “...managing appropriate preventive, health, remedial, **self-management**, and supportive care...”
 - (7) **We suggest that the description of the ACO board** composition, as outlined above in Section A.4, be added here.

3. Patient Centered Primary Care Home Services

- a. 414.760 Person Centered Primary Care Home Services
 - (1) We suggest the following change: “... shall establish **the standards already outlined by the OHPB Standards and Metrics Committee...and give preference in contracting with ACOs to those entities demonstrating the establishment, initially, and progress, over time, towards becoming a PCPCH for all their patients...**”

C. LC Section -- Related Implementation Recommendations

1. We recommend the addition of a section stipulating that, “**The OHA shall establish a learning community among ACOs to facilitate learning and spread of best practices.**”

2. We believe that Oregon needs examples of ACOs and needs to begin learning from trailblazers as soon as possible. Therefore, we recommend that upon passage of this legislation, any group of entities capable of collectively meeting these standards should be supported in becoming an ACO – they should not be required to wait until others are able to organize and compete for state support.

From: "Pete Runnels" <peterunnels@rocketmail.com>
To: <tina.d.edlund@state.or.us>
CC: <bruce.goldberg@state.or.us>, <mike.bonetto@state.or.us>
Date: 3/8/2011 11:52 AM
Subject: Judges/Commissioners out of process

Dear Health Transportation Team,

Please be advised of my deep concerns below regarding the Judges/Commissioners being left out as Local Mental Health and Public Health Authorities.

Given county responsibility for public safety, public health, mental health and the ancillary services necessary to provide the support people need in our counties we feel the language being proposed needs to include something similar to the following verbiage in the Discussion Draft - Part 2, Delivery System Changes

"The applicants will be required to establish a formalized relationship with local mental health authorities and local public health authorities which consists of coordination and significant influence in decision making. Applicants are required to get approval of the County Authorities in each County where they intend to provide service."

The current concept fundamentally changes the way we do business. We request to be at the table as well as address changes to the legislative concept being proposed.

Thank you for your consideration,

Pete Runnels
Harney County Commissioner
1100 N. Diamond Ave.
Burns, Oregon 97720

From: "Michael Troychak" <mtroychak@gmail.com>
To: <OHPB.Info@state.or.us>
CC: <OMA@theOMA.org>
Date: 3/8/2011 6:14 AM
Subject: Comments for Health System Transformation Team LC

Remember that there is no free lunch. Cutting the cost of care by cutting reimbursement to doctors means decreasing the supply and quality of doctors, and therefore the quality of care.

Remember that government control of anything, especially health care, always results in higher cost of care, because those in charge, especially politicians, always put their own power and position above everything else.

Remember that without meaning tort reform, cost containment gestures are not serious. Tort lawyers pump their financial windfalls back into the pockets of politician in order to make sure that the health care system is a lottery that bloats the costs that you claim to want to save, by unnecessary defensive medicine, etc.

Remember that it takes a long time to train a doctors, who tend to be ethical, and are the best in the world because the system rewards the best, or at least used to reward them. Politicians and lawyers, on the other hand, are a dime a dozen, have less training and academic achievement in general, and are of generally a lower ethical ilk.

So if you really care about the patients and their health, don't save a buck just by driving doctors and other providers out of patient care, rationing care, and then lining the pockets of the transparent phonies who pontificate about how much they care.

Michael Troychak, M.D.reimbursement

Comments Submitted by Public Health Advisory Board:

Health Systems Transformation Team
LEGISLATIVE CONCEPT
Preliminary Synopsis for Discussion Purposes

Primary Sources:

Oregon Health Policy Board – Oregon’s Action Plan for Health (Dec. 2010)
And reports of OHPB advisory groups
Governor Kitzhaber’s Budget Report (January 2011)
Meetings of the Health System Transformation Team

Assumptions:

- This LC does not make any changes to eligible populations or covered benefits.
- This LC uses the existing statutory framework in ORS Chapter 414 (Medical Assistance) to describe changes to statute appropriate for transformed delivery system that applies integrated health and services.
- This LC develops strategies to align a transformed delivery system with the federal Accountable Care Act.

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Key features of LC discussion draft:

- Goals and policies for integrated health care and services
 - Adopt the goals of improving the health of Oregonians, increasing quality, reliability and availability of care, and reducing costs of care.
 - Care and services are integrated and coordinated, including physical health, mental health, addictions treatment, oral health, home and community based services, and long term care services and support.
 - Consumers get the care and services they need, coordinated locally with access to statewide resources when needed.
 - People are at the center of coordinated care and services delivered through accountable care organizations using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve health and health care.
- An accountable care organization is a single integrated organization that accepts responsibility for the cost and health of the people within its global budget and for delivery, management and quality of the full continuum of care delivered to the specific population enrolled with the ACO.
- Essential elements of an ACO include (summarized);
 - (a) Work cooperatively with state and community partners to address public health issues;
 - (b) Improving health equity is prioritized through strategies that include but are not limited to increased allocation of resources for traditionally underserved communities, and increased participation and influence by traditionally underrepresented populations with the primary objective of reducing health disparities;
 - (c) Actively engages consumers in making its decisions that impact the populations it serves, the communities where it is located, and decisions about how integrated care is delivered;
 - (d) Person-centered, providing integrated person-centered care and services designed to provide choice, independence and dignity;

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Health Systems Transformation Team
LEGISLATIVE CONCEPT
Preliminary Synopsis for Discussion Purposes

- (e) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery, including comprehensive transitional care;
 - (f) Local access to care, including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved individuals and populations, and successful, effective referral to community and social support services, with access to statewide resources when needed;
 - (g) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate;
 - (h) Strong safeguards for consumers are established;
 - (i) Prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services;
 - (j) ACO providers are educated about the integrated approach, emphasize preventive resources, healthy lifestyle behaviors and evidence-based practices, shared decision-making, and communication; Deleted: work
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 - (k) Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual's needs as a whole person, and work with the individual to develop an individual care and service plan;
 - (l) Quality indicators are used; and
 - (m) Demonstrate excellence of operations.
 - (n) Ten percent of each ACO's global budget shall be directed to improving public health infrastructure for community supports within its service area. Deleted: the
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- Related implementation changes and key definitions
 - Use of information and confidentiality
 - Cooperation & delegation of authority between OHA and DHS
 - Grant authority for demonstration on integrated services for individuals who are dually eligible for Medicare and Medicaid
 - Authority to seek federal approvals

NOTE: This LC does not attempt to identify all possible conforming amendments, pending review and comment on the LC.

Legislative Concept Discussion Draft – Part 1

GOALS AND POLICIES

AMEND current law with updated goals and findings

GENERAL PROVISIONS

414.018 Goals; findings. (1) It is the intention of the Legislative Assembly to achieve the goals of improving the lifelong health of all Oregonians, increasing the quality, reliability and availability of care for all Oregonians; and ~~both lowering cost and containing the inflationary cost of care so that care is affordable and accessible for~~ everyone.

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(2) The Legislative Assembly finds:

(a) A significant level of public and private funds is expended each year for the provision of health care to Oregonians;

(b) The state has a strong interest in assisting Oregon businesses and individuals to obtain reasonably available insurance or other coverage of the costs of necessary basic health care services;

(c) The lack of basic health care coverage is detrimental not only to the health of individuals lacking coverage, but also to the public welfare and the state's need to encourage employment growth and economic development, and the lack results in substantial expenditures for emergency and remedial health care for all purchasers of health care including the state; and

(d) The use of integrated health care and services systems has significant potential to reduce the growth of health care costs incurred by the people of this state.

(3) The Legislative Assembly finds that achieving its goals of improving health, increasing the quality, reliability and availability of care, and reducing ~~and containing~~ costs requires an accountable and integrated health system:

(a) All health care and services are coordinated, including physical health, mental health, ~~public health~~, addictions treatment, oral health, home and community based services, and long term care services and support;

(b) Including long term care supports and services in the transformed health system promotes and encourages greater utilization of home and community based services, with nursing facility care used primarily for transition services;

(c) Services for Oregonians who are eligible for ~~either Medicare or Medicaid~~ are included within the transformed health system;

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(d) People are at the center of coordinated care and services delivered through accountable coordinated care contracts using alternative payment methodologies that shift the focus to prevention, improve health equity, and utilize person-centered primary care homes, evidence-based practices and health information technology to improve ~~the~~ health ~~of people~~ and health care;

(e) ~~Using needs assessment methods and data recognized by CMS, (What does CMS mean?~~ communities and regions are accountable for improving the health of ~~all people in~~ their communities, reducing avoidable health gaps among different cultural groups and managing health care and service resources; and

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(f) High quality information is collected and used to measure health ~~risk factors,~~ ~~health~~ outcomes, quality, costs, and clinical health information.

Legislative Concept
Discussion Draft – Part 1

GOALS AND POLICIES

AMEND current law with updated legislative intent (from OHPB Report p. 5)
OREGON ACCOUNTABLE HEALTH CARE AND SERVICES SYSTEM

414.610 Legislative intent. It is the intent of the Legislative Assembly to develop and implement new strategies to achieve an accountable and integrated system that improves health, increases the quality, reliability and availability of care, and reduces costs by creating a system in which:

- (1) Everyone is a consumer of health care and services
- (2) Consumers get the care and services they need, coordinated locally with access to statewide resources when needed, by a team of health professionals who understand their culture and speak their language; Deleted: to
- (3) Consumers, providers, community leaders and policymakers have the high-quality information they need to make better decisions and keep delivery systems accountable; Deleted: 2
- (4) Quality and consistency of care are improved and costs are contained through new payment systems and standards that emphasize outcomes and value rather than volume; Deleted: 3
- (5) Communities and health systems work together to find innovative solutions to reduce overall spending, increase access to care and improve health; and Deleted: 4
- (6) Electronic health information is available when and where it is needed to improve health and health care through a secure, confidential health information exchange. Deleted: 5

AMEND current statute

- 414.620 System established.** (1) The Oregon Accountable Health Care and Services System is established. Deleted: here is established t
The system shall consist of state policies and actions that make integrated care and services organizations accountable for care management and the provision of integrated health care and services for eligible persons, managed within a fixed budget by providing care better so that efficiency and quality improvements address medical inflation and caseload growth, and take these actions in a way that supports development of regional accountability for health, while maintaining the regulatory controls necessary to assure quality and affordable health services to all Oregonians. Deleted: , to the extent possible,
- (2) The Accountable Health Care and Services System shall pay for quality while managing within a global budget. The system shall hold accountable care organizations and their health care teams responsible for the quality and efficiency of care they provide, reward good performance and keep total spending to a global budget that limits cost increases. Within the health care system, restructured payments and incentives shall reward comprehensive care coordination in new delivery models such as person-centered primary care homes. Deleted: should
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- (3) Accountable care organizations shall be required to establish formalized relationships with local mental health authorities and local public health authorities, which consists of coordination and significant influence in decision making. ACOs shall Deleted: The applicants
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**Legislative Concept
Discussion Draft – Part 1**

GOALS AND POLICIES

~~be required to obtain approval of the county authorities in each county where they propose to provide services.~~

(4) Alternative payment methodologies or methods will be used, that move from predominantly fee-for-service to alternate payment methods, in order to base reimbursement on quality and results rather than volume of services.

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**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

AMEND existing statute to describe procurement and requirements for accountable care organizations

414.725 Accountable care organization contracts; financial reporting; rules. Except as limited by subsection (3):

(1)(a) Pursuant to rules adopted by the Oregon Health Authority, the authority shall execute accountable care organization contracts for integrated health care and services funded by the Legislative Assembly. The contract must require that all health services defined in ORS 414.705(2) are provided to the extent and scope of the Health Services Commission's report for each service provided under the contract. The contracts are not subject to ORS chapters 279A and 279B, except ORS 279A.250 to 279A.290 and 279B.235. Notwithstanding ORS 414.720 (8), the rules adopted by the authority shall establish timelines for executing the contracts described in this paragraph.

(b) It is the intent of ORS 414.705 to 414.750 that the Oregon Health Authority use, to the greatest extent possible, accountable care organizations receiving global payments to provide integrated physical health, dental, mental health, public health, chemical dependency, home and community based, and long term care and support services under ORS 414.705 to 414.750.

(c) The authority shall solicit qualified providers and plans that meet the standards established in ORS 414.xxx [see new statute below] to be reimbursed for providing the covered integrated services as part of an accountable and coordinated health system. The contracts may be with hospitals and medical organizations, health maintenance organizations, managed health care plans and all other qualified public or private organizations that meet the qualifications for an accountable care organization. After contracts are awarded pursuant to this section, the authority may negotiate with any successful proposal respondent for the expansion or contraction of service areas if there are potential gaps or duplications in service areas.

(d) (A) The authority shall establish annual financial reporting requirements for accountable care organizations. The authority shall prescribe a reporting procedure that elicits sufficiently detailed information for the authority to assess the financial condition of each accountable care organization and that includes information on the three highest executive total compensation (salary and benefit) packages of each accountable care organization.

(B) The membership of the governing board of an ACO shall reflect the diversity of the population served.

(e) The authority shall require compliance with the provisions of paragraph (d) of this subsection as a condition of entering into a contract with an accountable care organization.

(f)(A) The authority shall adopt rules and procedures to ensure that a rural health clinic that provides a health service to an enrollee of an accountable care organization receives total aggregate payments from the organization, other payers on the claim and the authority that are no less than the amount the rural health clinic would receive in the authority's fee-for-service payment system. The authority shall issue a payment to the

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Legislative Concept
Discussion Draft – Part 2

DELIVERY SYSTEM CHANGES

rural health clinic in accordance with this subsection within 45 days of receipt by the authority of a completed billing form.

(B) “Rural health clinic,” as used in this paragraph, shall be defined by the authority by rule and shall conform, as far as practicable or applicable in this state, to the definition of that term in 42 U.S.C. 1395x(aa)(2).

(2) The authority may contract for alternative integrated care services for the delivery of integrated services for persons eligible for health services under ORS 414.705 to 414.750 in designated areas of the state as long as the alternative arrangement meets the requirements of ORS 414.xxx. For purposes of this chapter, a reference to a qualified entity providing integrated services under contract with the authority pursuant to this subsection shall be a reference to an accountable care organization, or alternative integrated care service to the extent the Oregon Health Authority determines appropriate.

Comment [BAS1]: What does this mean? This needs to be defined.

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(3) The aggregate expenditures by the authority for integrated services provided pursuant to ORS 414.705 to 414.750 may not exceed the total dollars appropriated for integrated services under ORS 414.705 to 414.750.

Comment [BAS2]: This section is unclear. What is the intent of this section?

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(4) Actions taken by providers, potential providers, contractors and bidders in specific accordance with ORS 414.705 to 414.750 in forming consortiums or in otherwise entering into contracts to provide integrated services shall be performed pursuant to state supervision, shall be considered to be conducted at the direction of this state, and shall be considered to be lawful trade practices and may not be considered to be the transaction of insurance for purposes of the Insurance Code.

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(5) Health care providers contracting with accountable care organizations to provide services under ORS 414.705 to 414.750 shall advise an ACO member of any service, treatment or test that is medically necessary or that could slow progression of loss of function but not covered under the contract if an ordinarily careful practitioner in the same or similar community would do so under the same or similar circumstances.

(6) An accountable care organization shall provide information on contacting available providers to an ACO member in writing within 30 days of assignment to the accountable care organization.

(7) Each accountable care organization shall provide upon the request of an ACO member or prospective member annual summaries of the organization’s aggregate data regarding:

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(a) Grievances and appeals; and

(b) Availability and accessibility of services provided to members.

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(8) An accountable care organization may not limit enrollment in a designated area based on the zip code of an ACO member or prospective member.

Comment [BAS3]: Use of “member” instead of “enrollee” needs to be consistent throughout the document.

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NEW STATUTE to adopt “ESSENTIAL ELEMENTS” integration and accountability standards

ORS 414.xxx Essential elements for accountable care organization

Accountable care organizations are responsible for the full continuum of care for a defined population. Each accountable care organization or alternative integrated care system shall, at a

**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

minimum, have or obtain through contractual arrangement, the following functional capacities in accordance with the standards and contracts established by the Oregon Health Authority:

- (1) Accountable care organizations improve the quality of care, lower health care cost, and improve health and well-being of their members.
 - (a) The organization is accountable for the overall health of children and adult members in their area, and for working cooperatively with community partners to address public health issues that affect the health of the community.
 - (b) Health equity is prioritized and disparities are reduced. ACO organizational structures, including governance structures, must include ethnically diverse populations in the community, consumers including seniors, people with disabilities and people using mental health services, and ensure that ACO decision-making reflects the views of providers and consumers in the ACO network.
 - (c) Membership of the governing body of an ACO reflects the population served so that the organization is responsive to consumers in making its decisions that impact the populations served, the communities where it is located, and about how integrated care is delivered.
- (2) Accountable care organizations are person-centered organizations that provide integrated person-centered care and services designed to provide choice, independence and dignity:
 - (a) Individuals have a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery that address preventive, supportive and therapeutic needs of the individual in a holistic fashion, using person-centered primary care homes, community supports and individual care plans to the extent feasible, and that provides assistance in navigating the system if needed;
 - (b) Individuals receive comprehensive transitional care, including appropriate follow-up, when entering and leaving inpatient hospital or nursing facility to other care settings or return to their home;
 - (c) Access to services and supports are geographically located as close to home as possible, including use of community health workers and nontraditional settings that are accessible to families, diverse communities and underserved populations, and referral to community and social support services, with access to statewide resources when needed;
 - (d) Use of health information technology links services and care providers across the continuum of care and services as feasible and appropriate; and
 - (e) Strong safeguards for consumers are established, including safeguards against underutilization of services and protections against inappropriate denials of services or treatments in connection with utilization of alternative payment methods or transition to a global payment system.
- (3) Accountable care organizations prioritize working with ACO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive medicine, health promotion, remedial and supportive care and services, and reducing the use of services provided in emergency rooms and hospital readmissions.

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**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

- (4) Health care shall be delivered by Health Care Teams (HCTs) employed by or under contract with accountable care organizations.
- (a) The members of each Health Care Team shall include all medical assistance providers and other personnel appropriate to the level of service of that HCT, as determined by its ACO, and consistent with rules adopted to implement this Act.
 - (b) An HCT shall work with each of its patients to develop his or her integrated care and service plan, and shall interface with public health and community resources appropriate to that patient's needs as a whole person.
 - (c) Each HCT shall apply best practices for integrated care and service to improve the health and wellbeing of each of its patients and shall deliver such care and services efficiently, effectively, and economically.
 - (d) Each member of an HCT shall be knowledgeable about the integrated health care and services system and how to access and communicate within the integrated system about an individual patient's integrated care and service plan, risk factors, and health history.
 - (e) Each member of an HCT shall emphasize the use of preventive resources, health promotion, healthy lifestyle behaviors, evidence-based practices, shared decision-making, and transparent communication.
 - (f) HCTs shall maximize the use of electronic health records to assure continuity of care across the health care services delivery system.
- (5) Quality indicators are evaluated to assess ongoing health status of individuals, including demographic, risk and diversity data, consistent with standard quality measures adopted by and timely reported to the Oregon Health Authority to evaluate costs, experience of care, and population health.
- (6) Accountable care organizations demonstrate excellence of operations, including best practices in financial management capabilities, including but not limited to the management of claims processing and payment functions for ACO providers, and contract management capabilities, including but not limited to network provider creation and management functions.

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Deleted: Providers work in care teams responsible for individuals, including providers and community resources appropriate to the individual's needs as a whole person, and work with the individual to develop an individual care and service plan

Deleted: Providers maximize use of electronic health records to assure continuity of care across the service delivery system

NEW – Language for the service delivery expectations for individuals who are dually eligible –

414.xxx Conditions for coverage for certain individuals who are dually eligible for Medicare and Medicaid (1) Accountable care organizations that meet the standards established in ORS 414.xxx [above] are responsible for providing Medicare and Medicaid services to individuals who are dually eligible, including obtaining any necessary authorization from Medicare.

(2) Care and services for individuals who are dually eligible must emphasize preventive services, and services supporting independence and continued residence at home or in their community. Services for individuals who are dually eligible must be person-centered, and provide choice, independence and dignity reflected in individual plans and assistance with accessing care and services.

**Legislative Concept
Discussion Draft – Part 2**

DELIVERY SYSTEM CHANGES

(3) The Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services to seek approval of contracting procedures and blended reimbursement methods for accountable care organizations responsible for enrolled individuals who are dually eligible.

AMEND Current statute for patient-centered primary care home services –

414.760 Person centered primary care home services. (1) The Oregon Health Authority shall establish standards for implementation and utilization of person centered primary care homes and encourage their use as Health Care Teams in contracts with accountable care organizations and alternative integrated care systems. If practicable, efforts to align financial incentives to support person centered primary care homes for enrollees in medical assistance programs should be aligned with efforts of the learning collaborative described in ORS 442.210 (3)(d).

(2) Each accountable care organization shall implement, to the maximum extent feasible, person centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations. The organization shall require its other health and services providers to communicate with the primary care home in a timely manner and participate in care coordination including use of electronic health information technology. The authority shall reimburse person centered primary care homes for interpretive and other enabling services provided to people in the state’s medical assistance programs if such services qualify for federal financial participation.

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(3) The authority shall require person centered primary care homes receiving these reimbursements to report on quality measures described in ORS 442.210 (1)(c).

**Legislative Concept
Discussion Draft – Part 3**

RELATED IMPLEMENTATION RECOMMENDATIONS

NEW STATUTE for coordination and delegation of authority between DHS and OHA for implementation

- (1) The Department of Human Services and the Oregon Health Authority shall cooperate with each other by coordinating actions and responsibilities necessary to implement an accountable and integrated health and service delivery system in accordance with this 2011 Act, in a manner consistent with the responsibilities of the authority for the medical assistance program pursuant to ORS 413.032.
- (2) The department and the authority may delegate to each other any duties, functions or powers that the department and the authority deem necessary for the efficient and effective operation of their respective functions for purposes of this 2011 Act.

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NEW STATUTE for use of information sharing and confidentiality

414.xxx Disclosure and use of medical assistance records by ACOs limited; contents as privileged communication; exceptions. (1) A hallmark of integrated accountable care organizations' effective management and service delivery is the appropriate use of ACO member information which includes use of electronic health information and administrative data that is available when and where it is needed to improve health and health care through a secure, confidential health information exchange.

(2) ACO members must have access to their personal health information, in the manner provided in 45 CFR 164.524, so they can share it with others involved in their care and make better health care and lifestyle choices.

(3) An accountable care organization and its provider network shall use and disclose ACO member information for purposes of service and care delivery, coordination, service planning, transitional services, reimbursement, and the requirements of this chapter, in order to improve the safety and quality of care, lower the cost, and improve health and well-being of their members. Integrated whole-person care necessarily requires access to and use of information about all aspects of the person's health and mental health condition, and sensitive diagnosis information including HIV and other health and mental health diagnoses, within the accountable care organization. Such uses and disclosures by the accountable care organization and its providers for purposes of providing integrated health care and services is required by law in accordance with this section. Individually identifiable health information must be treated as confidential and privileged information subject to ORS 192.518 to 192.526 and applicable federal privacy requirements, and redisclosures outside of the accountable care organization and its providers for purposes unrelated to this section or the requirements of this chapter remain subject to any applicable state privacy requirements.

(4) For the protection of ACO members, except as otherwise provided in this section, an accountable care organization and its providers shall not disclose or use the contents of any records, files, papers or communications for purposes other than those directly connected with the administration of the ACO and the public assistance laws of Oregon, or as necessary to assist the ACO members in accessing and receiving other

**Legislative Concept
Discussion Draft – Part 3**

RELATED IMPLEMENTATION RECOMMENDATIONS

governmental or private nonprofit services, and these records, files, papers and communications are considered confidential subject to the rules and regulations of the Oregon Health Authority. In any judicial or administrative proceeding, except proceedings directly connected with the administration of public assistance or child support enforcement laws, their contents are considered privileged communications.

(5) Nothing in this section prohibits disclosure of information between the ACO and its provider network, and the Oregon Health Authority and the Department of Human Services for the purpose of administering the public assistance laws of Oregon.

AMEND – This is the state mini-HIPAA privacy law; need to amend to address privacy issues

192.519 Definitions for ORS 192.518 to 192.529. As used in ORS 192.518 to 192.529:

(2) “Covered entity” means:

- (a) A state health plan;
- (b) A health insurer;
- (c) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 192.518 to 192.529; or
- (d) A health care clearinghouse.
- (e) An accountable care organization contracted with the Oregon Health Authority

AMEND current statute related to grant authority for demonstration on integrated services for individuals who are dually eligible

414.033 Expenditures for medical assistance authorized. The Oregon Health Authority may:

(1) Subject to the allotment system provided for in ORS 291.234 to 291.260, expend such sums as are required to be expended in this state to provide medical assistance. Expenditures for medical assistance include, but are not limited to, expenditures for deductions, cost sharing, enrollment fees, premiums or similar charges imposed with respect to hospital insurance benefits or supplementary health insurance benefits, as established by federal law.

(2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project which determines the cost of providing medical assistance to individuals who are dually eligible or to evaluates service delivery systems.

NEW STATUTE Necessary federal approvals may be requested

(1) To promote the adoption of alternative payment methodologies and contracting with ACOs, the Oregon Health Authority shall apply to the Centers for Medicare and Medicaid Services for

**Legislative Concept
Discussion Draft – Part 3**

RELATED IMPLEMENTATION RECOMMENDATIONS

any approval necessary to obtain federal financial participation in the costs of activities described in this 2011 Act, including but not limited to:

(a) Seeking federal approvals necessary to permit Medicare to participate in Oregon’s alternative payment and integrated service methodologies. Upon obtaining federal approval for Medicare participation, such participation shall be commenced and continued and the authority shall seek extensions or additional approvals, as necessary.

(b) Seeking federal approvals necessary to support the transition to and implementation of global and alternative payment systems, and formation and utilization of ACOs in the medical assistance program.

(2) The authority shall adopt rules implementing the provisions of this 2011 Act requiring federal approval as soon as practicable after receipt of the necessary federal approval and may provide for implementation in stages in accordance with the availability of funding.

(3) Sections of this 2011 Act requiring federal approvals become operative on the later of _____, or the date on which the Oregon Health Authority receives any federal approval required to secure federal financial participation under subsection (1) of this section.

**Legislative Concept
Discussion Draft – Part 4**

KEY DEFINITIONS

AMEND current statute defining “medical assistance”

All relevant definitions should be included in 414.025, not there or in 414.705

414.025 Definitions. As used in this chapter, unless the context or a specially applicable statutory definition requires otherwise:

*** [NO CHANGES IN POPULATIONS COVERED OR DEFINITIONS OF “INCOME” OR “INVESTMENTS AND SAVINGS”]

(5) “Medical assistance” is synonymous with “integrated health care and services” or “integrated services”, which means so much of the following preventive, medical, remedial and supportive care and services as may be funded by the Legislative Assembly and prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032, including payments made for services provided under an insurance or other contractual arrangement and money paid directly to the recipient for the purchase of medical care:

Comment [BAS1]: “Integrated health care and services” or “integrated services” should be included in the alphabetical list of definitions, followed by “see Medical assistance”

(a) Inpatient hospital services, other than services in an institution for mental diseases;

(b) Outpatient hospital services;

(c) Other laboratory and X-ray services;

(d) Skilled nursing facility services, other than services in an institution for mental diseases, and other long term care services and supports;

Comment [BAS2]: Unclear. Is the last clause included or excluded?

(e) Physicians’ services, whether furnished in the office, the patient’s home, a hospital, a skilled nursing facility or elsewhere;

(f) Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(g) Home health care services;

(h) Private duty nursing services;

(i) Clinic services;

(j) Dental services;

(k) Physical therapy and related services;

(L) Prescribed drugs, including those dispensed and administered as provided under ORS chapter 689;

(m) Dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select;

(n) Other diagnostic, screening, preventive and rehabilitative services;

(o) Inpatient hospital services, skilled nursing facility services and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;

(p) Any other medical care, and any other type of remedial care recognized under state law;

**Legislative Concept
Discussion Draft – Part 4**

KEY DEFINITIONS

(q) Periodic screening and diagnosis of individuals under the age of 21 years to ascertain their physical or mental impairments, and such health care, treatment and other measures to correct or ameliorate impairments and chronic conditions discovered thereby;

(r) Inpatient hospital services for individuals under 22 years of age in an institution for mental diseases;

(s) Hospice services;

(t) Home and community based services;

(u) Mental health services; and

(v) Chemical dependency services.

(w) Health services as defined in subsection (6)

(x) Any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. “

“Medical assistance” does not include care or services for an inmate in a nonmedical public institution.

(6). Transfer all of 414.705(3).

(7). “Health disparity” means a difference in which disadvantaged social groups systematically experience worse health outcomes or greater health risks than more advantaged social groups.

(7) [OMIT DEFINITION OF MEDICALLY NEEDY – NOT CHANGED; COULD BE REPEALED, SINCE NO MEDICALLY NEEDY PROGRAM AT THIS TIME]

(8) [OMIT DEFINITION OF RESOURCES – NOT CHANGED]

(9) “Individual who is dually eligible” means an individual who is entitled to, or enrolled for, benefits under Part A of Title XVIII, or enrolled for benefits under Part B of Title XVIII, and is eligible for medical assistance under Title XIX of the Social Security Act in accordance with this chapter.

(10) “Person-centered primary care home” means a primary care team or clinic which is organized in accordance with standards as defined by the Oregon Health Authority and which incorporates the following core attributes:

(a) Access to integrated health care and services;

(b) Accountability;

(c) Comprehensive whole person care;

(d) Continuity;

(e) Coordination and integration with population level health promotion interventions;

(f) Person and family centered care; and

(g) Connection to community resources that support and sustain health and health promoting behavior.

Deleted: (6) “Medical assistance” includes any care or services for any individual who is a patient in a medical institution or any care or services for any individual who has attained 65 years of age or is under 22 years of age, and who is a patient in a private or public institution for mental diseases. “Medical assistance” includes “health services” as defined in ORS 414.705. “Medical assistance” does not include care or services for an inmate in a nonmedical public institution.¶

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**Legislative Concept
Discussion Draft – Part 4**

KEY DEFINITIONS

(10) “Accountable care organization” or “ACO” means a single integrated organization that accepts responsibility for the health of the specific population of persons enrolled with the ACO, including the cost, delivery, management, and quality of care delivered to those persons within its global budget and which operates consistent with the principles of a person-centered primary care home and satisfies the other requirements of this chapter; which has a formal legal structure to receive global payments and distribute payments and savings; and which complies with any federal requirements applicable to

ACOs, however named. An ACO may include an alternative innovative integrated health and services arrangement approved by the authority in accordance with ORS 414.725.

(11) “ACO member” means an individual who receives integrated medical, remedial and supportive care and services through an accountable care organization.

(12) “Alternative payment methodologies or methods” means methods of payment that are not fee-for-service based and that are used by ACOs to compensate their providers for the provision of integrated health care and services, including but not limited to shared savings arrangements, bundled payments, episode-based payments, and global payments, as defined by rules adopted by the Oregon Health Authority. No payment based on the fee-for-service methodology shall be considered an alternative payment.

(13) “Quality measures” means objective benchmarks established in accordance with nationally accepted performance metrics and as otherwise permitted under this chapter for assessing provider and ACO performance.

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Deleted: and for delivery, management and quality of care delivered to the specific population of patients enrolled with the ACO;

Deleted: **AMEND current statute to define “integrated health care and services”**

414.705 Definitions for ORS 414.705 to 414.750. (1) As used in ORS 414.705 to 414.750, “integrated health care and services” or “integrated services” means at least so much of medical assistance as defined in ORS 414.025, including health services, as may be prescribed by the Oregon Health Authority according to the standards established pursuant to ORS 413.032 and that are approved and funded by the Legislative Assembly.

(2) “Health disparity” is a difference in which disadvantaged social groups systematically experience worse health outcomes or greater health risks than more advantaged social groups.

(3)

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Deleted:) “Health services” means so much of the following care and services funded by the Legislative Assembly in accordance with the prioritized list of health services under ORS 414.720:

(a) Services required by federal law to be included in the state’s medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner’s practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than

services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state’s medical ass ... [1]

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(7) Define “provider”

(8) Define “health care team”

¶

¶

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) “Health services” means so much of the following care and services funded by the Legislative Assembly in accordance with the prioritized list of health services under ORS 414.720:

(a) Services required by federal law to be included in the state’s medical assistance program in order for the program to qualify for federal funds;

(b) Services provided by a physician as defined in ORS 677.010, a nurse practitioner certified under ORS 678.375 or other licensed practitioner within the scope of the practitioner’s practice as defined by state law, and ambulance services;

(c) Prescription drugs;

(d) Laboratory and X-ray services;

(e) Medical supplies;

(f) Mental health services;

(g) Chemical dependency services;

(h) Emergency dental services;

(i) Nonemergency dental services;

(j) Provider services, other than services described in paragraphs (a) to (i), (k), (L) and (m) of this subsection, defined by federal law that may be included in the state’s medical assistance program;

(k) Emergency hospital services;

(L) Outpatient hospital services; and

(m) Inpatient hospital services.

(4) Define “health and care services,” Define with clarity on what health services means. Does it include public health services?

(5) Define “public health issues”,

(6) Define “integrated health system.” Does it include public (population) health?

From: "Don Skundrick" <SkundrDW@jacksoncounty.org>
To: <bruce.goldberg@state.or.us>, <mike.bonetto@state.or.us>, <tina.d.edlund...>
Date: 3/9/2011 3:33 PM

As a County Commissioner I would strongly recommend that County Commissioners be allowed a seat at the table when discussions are underway concerning proposed changes in "delivery system changes" pertaining to Medicaid and the revised Oregon Plan. Given county responsibility for public safety, public health, mental health and the ancillary services necessary to provide the support people need we should propose the following addition to the language in the Discussion Draft—Part 2, Delivery System Changes. After the first sentence in 414.725 (c), please insert:

The applicants will be required to establish a formalized relationship with local mental health authorities and local public health authorities which consists of coordination and significant influence in decision making. Applicants are required to get approval of the county authorities in each county where they intend to provide services.

Thank you
Don Skundrick
Jackson County Commissioner

From: "Seth Bernstein" <sethbernstein@abhabho.org>
To: "Tina D EDLUND" <tina.d.edlund@state.or.us>
CC: "Gina Nikkel" <gnikkel@aocweb.org>, <jimr@mvbcn.org>, <glenn.rodriguez@p...>
Date: 3/6/2011 6:28 PM
Subject: RE: Health System Transformation Team FOLLOW UP

Tina:

Here is one specific recommendation (in bold and quotation marks below) to add to the "Goals and polices for integrated healht services" section of the document referenced below.

Source document: Health Systems Transformation Team, LEGISLATIVE CONCEPT, Preliminary Synopsis for Discussion Purposes

Key features of LC discussion draft:

* Goals and policies for integrated health care and services

"ACOs, as well as the providers they employ or contract with, are paid on the basis of performance and outcomes rather than how many individual services they provide."

Comment: as long as ACO and provider payment is widget-based, savings will never be achieved. The FFS payment methology will continue to drive maximum service roduction, resulting in continued high healthcare costs. This conclusion is evidence based. There is no expert in the field I know of who believes that healthcare reform can succeed without this change.

From: Tina D EDLUND [mailto:tina.d.edlund@state.or.us]
Sent: Thursday, March 03, 2011 12:01 PM
Cc: Alissa ROBBINS; Amanda SUTTON; Amy FAUVER; Bob Diprete; Bobbi DOAN;