

Oregon Health Policy Board
AGENDA
July 1, 2014
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m to 12:00 p.m.

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

#	Time	Item	Presenter	Action Item
1	8:30	Welcome, call to order and roll Action item: 6/3/14 minutes	Brian DeVore, Substitute Chair	X
2	8:35	Director's Report	Suzanne Hoffman, OHA	
3	8:50	Transition Project Update	Tina Edlund, Governor's Office	
4	9:05	Update on activities related to the 2013 OHPB Recommendations to the Governor	Leslie Clement, OHA	
5	9:15	CCM Alignment Update: PEBB Contracts	Kelly Ballas, OHA	
6	9:30	Oregon's Health System Transformation 2013 Performance Report	Lori Coyner, OHA	
7	10:15	Break		
8	10:30	Primary care for health system transformation <ul style="list-style-type: none"> • Patient-Centered Primary Care Home Program Update • Strategies for strengthening & monitoring primary care infrastructure 	Nicole Merrithew, OHA Lisa Angus, OHA	
9	11:30	Early Learning Hubs Update	Jada Rupley, Early Learning System Director	
10	11:45	Public Testimony	Substitute Chair	
11	12:00	Adjourn	Substitute Chair	

Next meeting:

August 5, 2014

1:00 p.m. to 5:00 p.m.

OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4

Oregon Health Policy Board

DRAFT Minutes

June 3, 2014

OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
1:00 p.m. to 4:00 p.m.

Item

Welcome and Call To Order

Vice Chair Dr. Carla McKelvey called the Oregon Health Policy Board (OHPB) meeting to order. All members were present except Mike Bonetto.

Leslie Clement and Suzanne Hoffman were present from the Oregon Health Authority (OHA).

Consent Agenda:

The meeting minutes from May 6, 2014 were unanimously approved.

Dr. McKelvey recognized and thanked Lisa Dodson for her many years of service in Oregon. She will be leaving the state of Oregon, moving to Wisconsin to be the Dean of the Wisconsin Medical College.

Director's Report – Suzanne Hoffman

Suzanne Hoffman provided leadership updates for the Oregon Health Authority. Judy Mohr Peterson will assist Tina Edlund at Cover Oregon during the transition of QHP eligibility and enrollment to the federal hub and Medicaid eligibility back to OHA. Rhonda Busek will be the interim director of DMAP with Bobby Green acting as the interim deputy director.

IT Transition Project Update – Tina Edlund – Governor's Office

Tina Edlund explained her transition from OHA to Cover Oregon to assist with the IT Transition Project.

Total Medical Enrollments: 285,578 (QHP Enrollments: 83, 852; OHP Enrollments: 201,726; Total Dental Enrollments: 16, 979). OHA Fast Track OHP Enrollments: 137,000. Total medial enrollments (Cover Oregon & OHA Enrollments (including Fast Track) 422,578.

The goal for November 15, 2014:

- Have Oregonians apply, shop and choose a private plan online all in one sitting;
- Those eligible for Medicaid will have a more streamlined process;
- Oregon retains control of the individual marketplace
 - Competition
 - Cost
 - Access

To accomplish the goal:

- Cover Oregon will use the federal technology for QHP eligibility and enrollment;
- OHA will build on existing technology investment for Medicaid eligibility

Milestones Timeline:

- June 30: Deloitte "gap analysis" final; system integrator awarded
- August 15*: Testing begins (*Precise date to begin testing will be determined after execution of System Integrator contract)
- November 15: 2015 open enrollment begins

View the Cover Oregon IT Transition Project Update presentation [here](#), starting on page 5.

Task Force on the Future of Public Health Services – Lillian Shirley, OHA and Tammy Baney, Deschutes County Commissioner

Lillian Shirley and Tammy Baney gave an overview of the Task Force on the Future of Public Health Services. The Task Force was established by legislation in 2013 and was charged with developing recommendations that:

- Create a public health system for the future
- Explore the creation of regional structures
- Enhance efficiency and effectiveness
- Allow for appropriate partnerships with regional health care service providers and community organizations
- Consider cultural and historical appropriateness
- Are supported by best practices

View the entire Task Force presentation [here](#), starting on page 23.

Policy Update – Leslie Clement – OHA

Leslie provided the following updates:

Measurement Framework

- Next iteration of the multi-payer dashboard will come to the Board today.

Sustainable health care expenditures workgroup (SHEW)

- First meeting occurred Thursday May 8th. Minutes are available on their website, accessible here: (<http://www.oregon.gov/oha/Pages/srg.aspx>).
- The specific goals of this group are to develop a methodology for calculating total annual healthcare expenditures at the statewide, carrier, and hospital levels; to calculate annual statewide expenditures for CYs 2011-2013; and to provide comments on data gaps and potential areas of improvement.
- The group will likely meet 5-6 times through November, and should present a finalized proposal at the OHPB December meeting.

Strengthening primary care investment & infrastructure

- Center for Health Care Strategies (CHCS) just completed an environmental scan of: potential strategies for supporting primary care infrastructure and investment and potential measures for tracking strength of the primary care system.
- This work will come to the Board for discussion in July.

Coordinated Care Model Alignment and Spread

- OHA is finalizing membership for the CCM Alignment workgroup.

Behavioral Health Integration

- Leslie provided an update on Douglas County and the mental health work moving to a non-profit organization. Leslie spoke with Umpqua CCO and the transition was very favorable.

- Town Hall meetings have been initiated with the first in Portland, then Bend, Seaside, Salem, Roseburg and Pendleton and will be completed by the end of June. There will be a more inclusive conversation with focus population discussions with the tribes and provide the presentation in Chinese and Spanish. One additional meeting will take place with the African-American community.
- A Straw model for the Behavioral Health System will be developed.
- Routine updates will be provided to the Board about the behavioral health integration efforts

Second OHPB Health System Dashboard Release – Gretchen Morley, Lori Coyner, Russell Voth – OHA

The Oregon Health Authority (OHA) presents this second edition of a dashboard to the Oregon Health Policy Board for review and feedback. OHA's intent is to provide a clear view of Oregon's health system from available data sources, including commercial insurance carriers, Medicare, Medicaid, health care providers, and population surveys. Trends will be tracked over time and new data sources will be added as they become available. By mapping the shifting terrain of Oregon's health care landscape, OHA seeks to inform the direction of policymakers, health care providers, insurers, purchasers and individuals.

The dashboard includes information on the following aspects of health and health care in Oregon:

- Health Care Cost and Utilization
- Health Insurance Coverage
- Quality of Care
- Medical Debt
- Health Status

Comments and suggestions from today's discussion will be reviewed and updated data will be brought back to the Board in the next meeting.

View the Second OHPB Health System Dashboard Release [here](#), starting on page 32.
View the Oregon Hospital Financial Performance presentation [here](#), starting on page 53.

Adjourn

Next meeting:

July 1, 2014

8:30 a.m. to noon

OHSU Center for Health & Healing

3303 S.W. Bond Ave., 3rd floor Rm. #4

Health System Transformation 2013 Performance Report

Oregon Health Policy Board
July 1, 2014

Lori Coyner
Director of Health Analytics

The logo for the Oregon Health Authority is centered on a light blue, curved background. It features the word "Oregon" in orange, "Health" in blue, and "Authority" in orange, all in a serif font. A thin blue horizontal line is positioned below the word "Health".

Oregon
Health
Authority

Oregon Health Authority accountability

State Performance Measures

- Annual assessment of statewide performance on 33 measures.
- Financial penalties to the state if quality goals are not achieved.

CCO Incentive Measures

- Annual assessment of CCO performance on 17 measures.
- Quality pool paid to CCOs for performance.
- Compare 2013 performance to 2011 baseline.



Quality Pool: Metrics and Scoring Committee

- 2012 Senate Bill 1580 establishes committee
- Nine members serve two-year terms. Must include:
 - 3 members at large;
 - 3 members with expertise in health outcome measures
 - 3 representatives of CCOs
- Committee uses public process to identify objective outcome and quality measures and benchmarks

Quality Pool: distribution

To earn their full quality pool payment, CCOs had to:

- ✓ Meet the benchmark or improvement target on at least 12 of the 17 measures; and
- ✓ Have at least 60 percent of their members enrolled in a patient-centered primary care home (PCPCH).

Money left over from quality pool went to the challenge pool.

To earn challenge pool payments, CCOs had to:

- ✓ Meet the benchmark or improvement target on the four challenge pool measures: depression screening, diabetes HbA1c control, SBIRT, and PCPCH enrollment.

Meeting goals and what they mean

The Metrics and Scoring Committee established a benchmark and/or improvement target for each incentive measure. Metrics and Scoring Committee reviews measures and targets each year for adjustment.

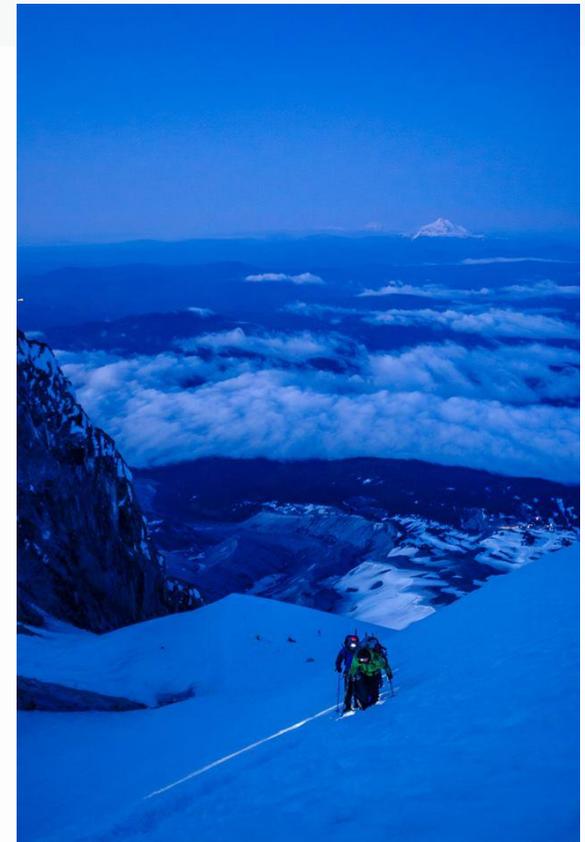
Benchmarks: These are national level benchmarks, set for exceptionally high achieving Medicaid programs. We would expect these to be reached in the long-term, rather than short term (5 to 10 years.) They may shift slightly year to year or be increased as needed.

Improvement targets: Each CCO has improvement targets for each incentive measure. Each target is based on the CCOs baseline. The baseline year moves forward requiring continued improvement.

2013 Performance Report: what's new?

- ✓ Final 2013 performance data on the CCO incentive metrics.
- ✓ Final 2013 performance data on the state performance metrics.
- ✓ 2013 Quality Pool (and challenge pool) distribution to CCOs.
- ✓ 2011 and 2013 data broken out by race and ethnicity.
- ✓ New grouper for cost and utilization data.

www.oregon.gov/oha/metrics/



MEASURING PROGRESS

How did CCOs do?

Incentive metrics

- 11 out of 15 CCOs met earned 100% of the quality pool
 - One CCO earned 70% and three earned 80%
- Incentive metrics: we saw statewide improvement on all 14 of the incentive measures included in the report

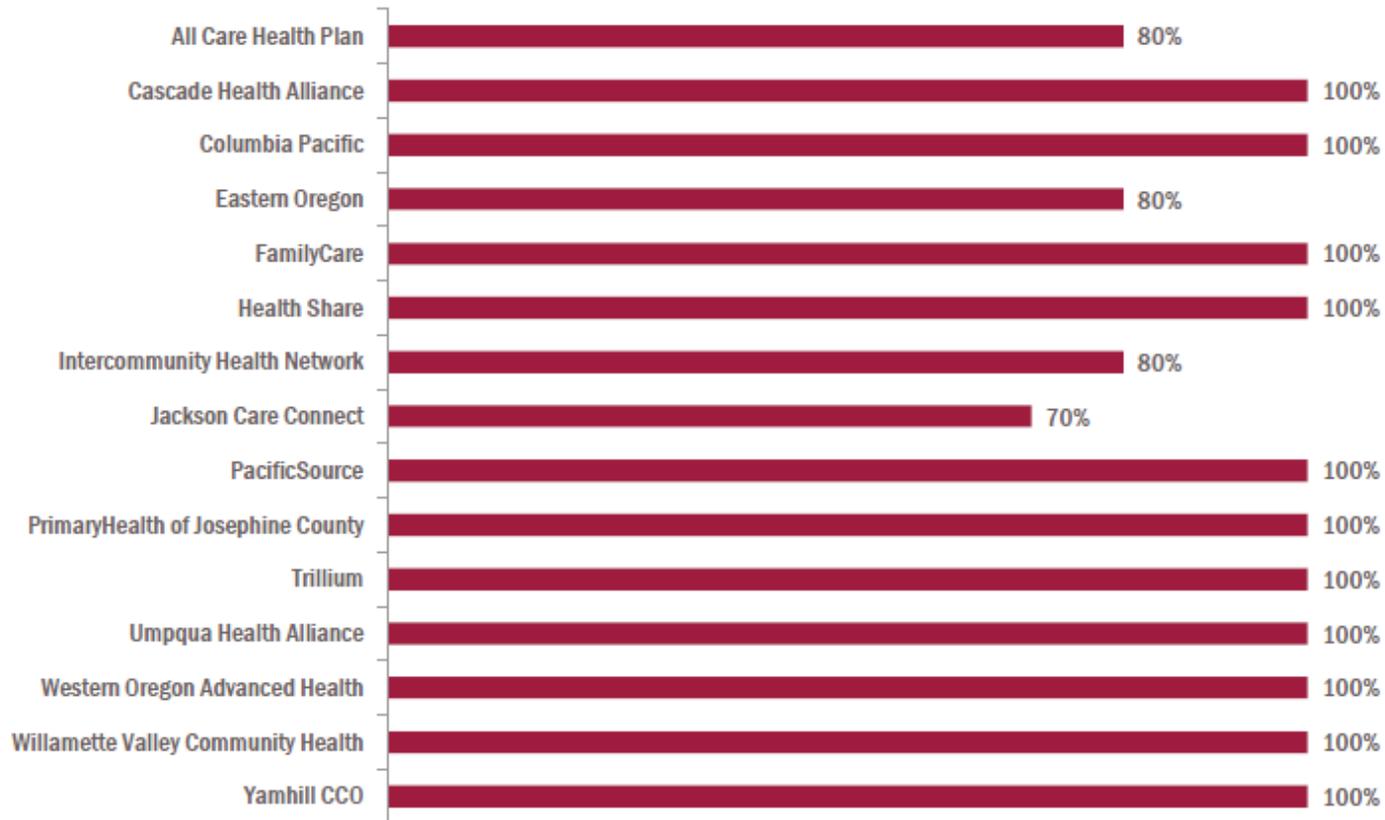
Statewide metrics – for reporting to CMS

- Of the 17 other metrics, we saw statewide improvement on 9 measures.
- There were just two measures where we didn't see any improvement statewide or at the CCO level.

How did CCOs do?

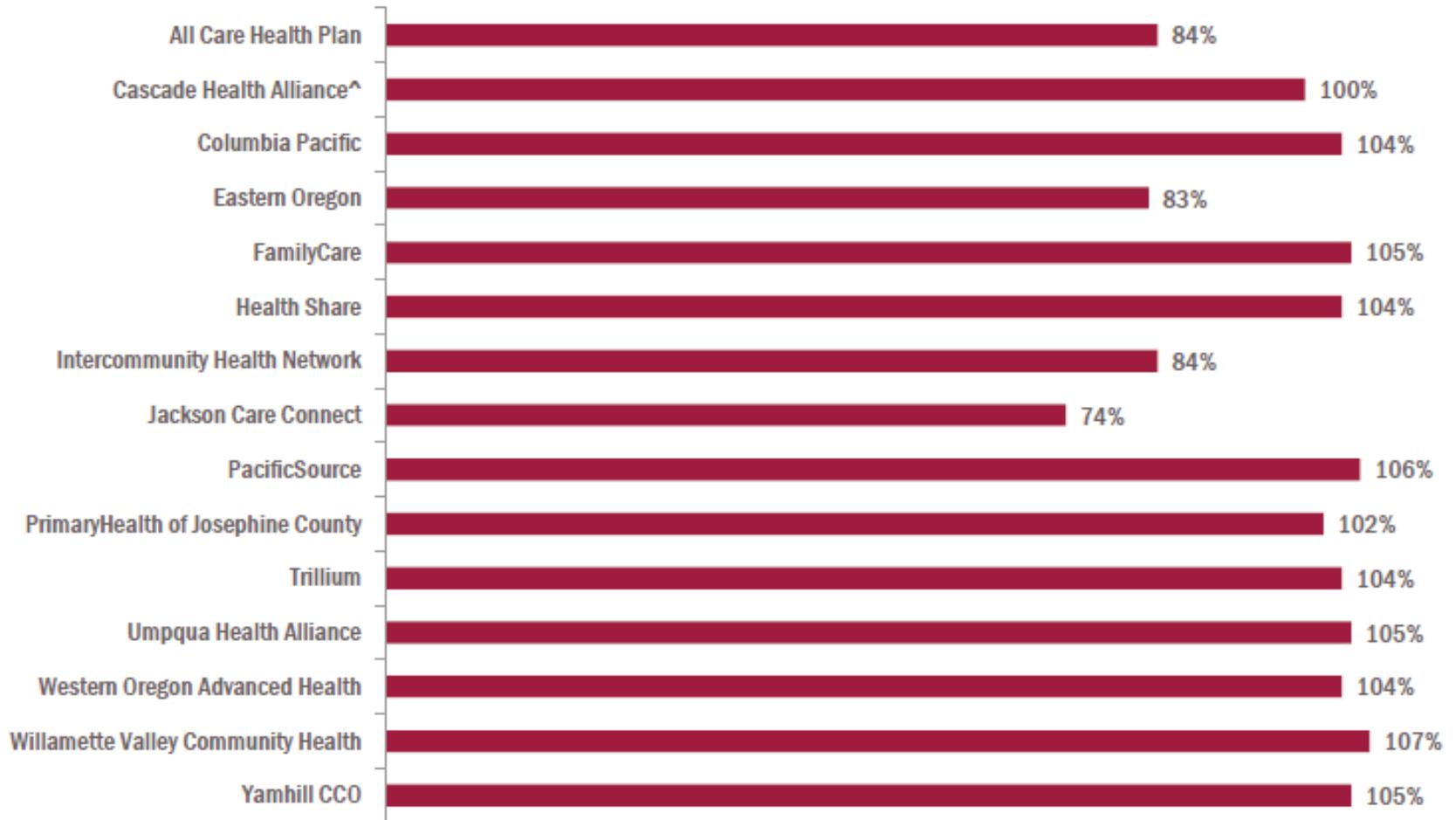
Percent of 2013 Quality Pool: Phase One Distribution Earned

Does not include Challenge Pool funds



Percent of 2013 Quality Pool Earned in Total

Includes both Phase One Distribution and Challenge Pool funds



^ Reflects prorated quality pool for partial year as CCO.

Coordinated Care Organization	Number of measures met*	Percent of total quality pool funds earned†	Total dollar amount earned	CCO Enrollment•	Which challenge pool measures were met
All Care Health Plan	11.6	84%	\$2,239,160	27,878	Diabetes, Depression
Cascade Health Alliance^	13.7	100%	\$748,517	10,153	Diabetes, Depression, PCPCH
Columbia Pacific	13.8	104%	\$1,461,310	14,413	Diabetes, Depression, PCPCH
Eastern Oregon	11.6	83%	\$1,961,432	29,234	Diabetes, PCPCH
FamilyCare	13.7	105%	\$4,354,150	50,064	Diabetes, Depression, PCPCH
Health Share	12.8	104%	\$13,720,133	148,201	Diabetes, Depression, PCPCH
Intercommunity Health Network	11.9	84%	\$2,669,122	32,728	Diabetes, Depression, PCPCH
Jackson Care Connect	11.4	74%	\$1,286,078	18,539	Diabetes, Depression
PacificSource	12.9	106%	\$3,452,010	36,667	Diabetes, Depression, PCPCH, SBIRT
PrimaryHealth of Josephine County	13.0	102%	\$1,024,938	5,957	Diabetes, Depression, PCPCH
Trillium	12.9	104%	\$4,949,647	49,677	Diabetes, Depression, PCPCH
Umpqua Health Alliance	13.7	105%	\$1,716,647	16,102	Diabetes, Depression, PCPCH, SBIRT
Western Oregon Advanced Health	14.7	104%	\$1,282,648	11,664	Diabetes, Depression, PCPCH
Willamette Valley Community Health	14.9	107%	\$4,987,244	64,044	Diabetes, Depression, PCPCH, SBIRT
Yamhill CCO	14.8	105%	\$1,137,005	13,368	Diabetes, Depression, PCPCH



MEASURING SUCCESS

Overall, all CCOs improved on...

Ambulatory care: emergency department utilization

- ✓ All CCOs met their improvement targets.

Developmental screening

- ✓ All CCOs met their improvement targets and four met benchmark.

Early elective delivery

- ✓ All CCOs were below the benchmark (lower is better).

Electronic Health Record (EHR) adoption

- ✓ All CCOs met their improvement target or surpassed benchmark.

Patient Centered Primary Care Home enrollment

Mixed results / progress on...

- **Adolescent well – care visits** (7 CCOs met targets)
- **Colorectal cancer screening** (6 CCOs met targets)
- **Follow up after hospitalization for mental illness** (10 CCOs)
- **Follow up care for children prescribed ADHD meds** (13 CCOs)
- **Assessments for children in DHS custody** (12 CCOs)
- **Prenatal and postpartum care** (11 CCOs made improvements)
- **Satisfaction with care** (12 CCOs made improvements)

Decreased ED utilization

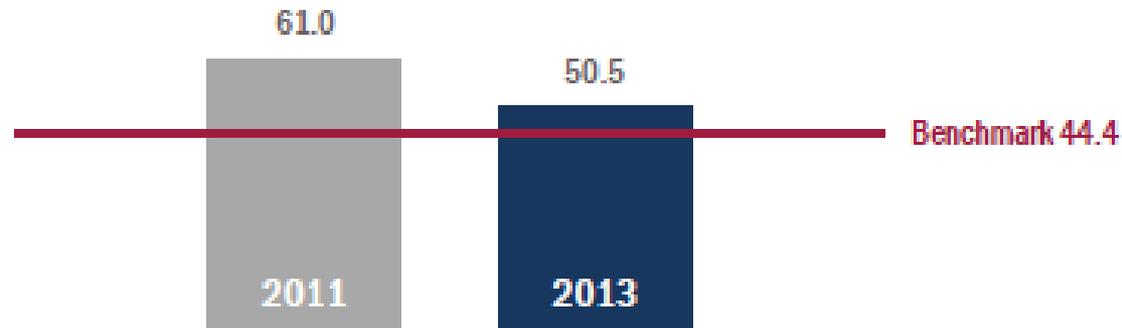
- ED visits decreased 17 percent since 2011.
- The cost of providing services in EDs decreased by 19 percent.

Statewide

(Lower scores are better)

Data source: Administrative (billing) claims

Benchmark source: 2012 National Medicaid 90th percentile



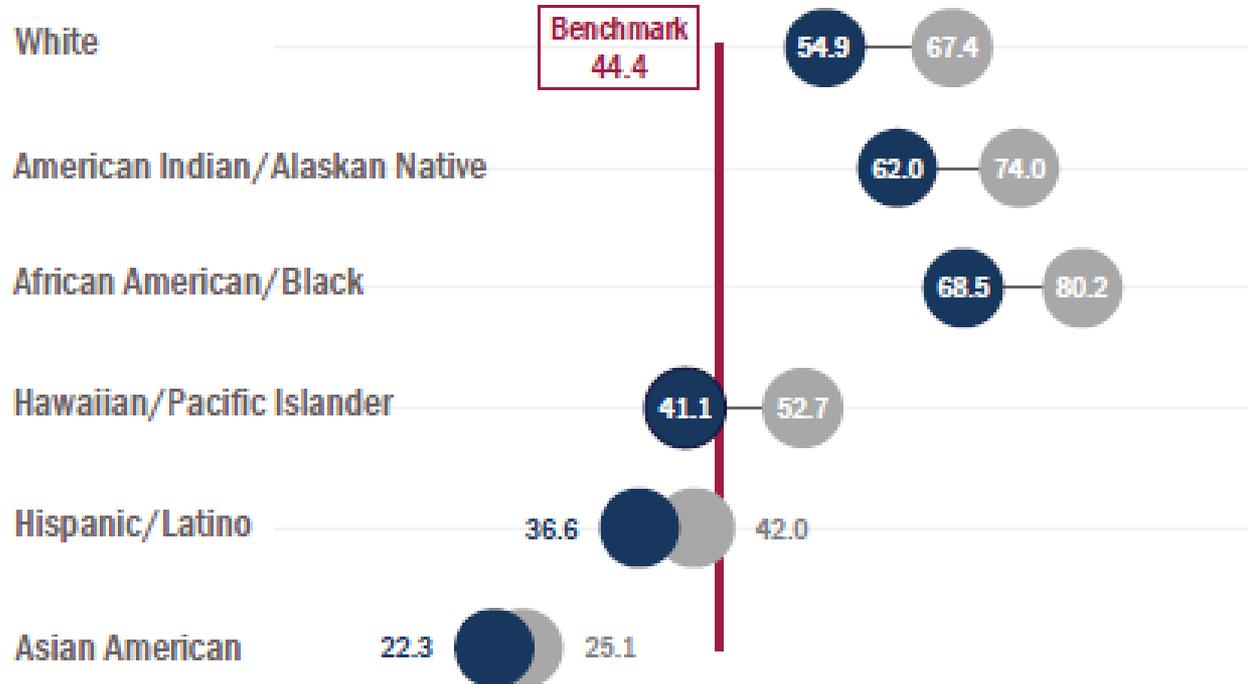
ED utilization by race & ethnicity

Race and ethnicity data between 2011 & 2013

(Lower scores are better)

Data missing for 7.4% of respondents

Each race category excludes Hispanic/Latino

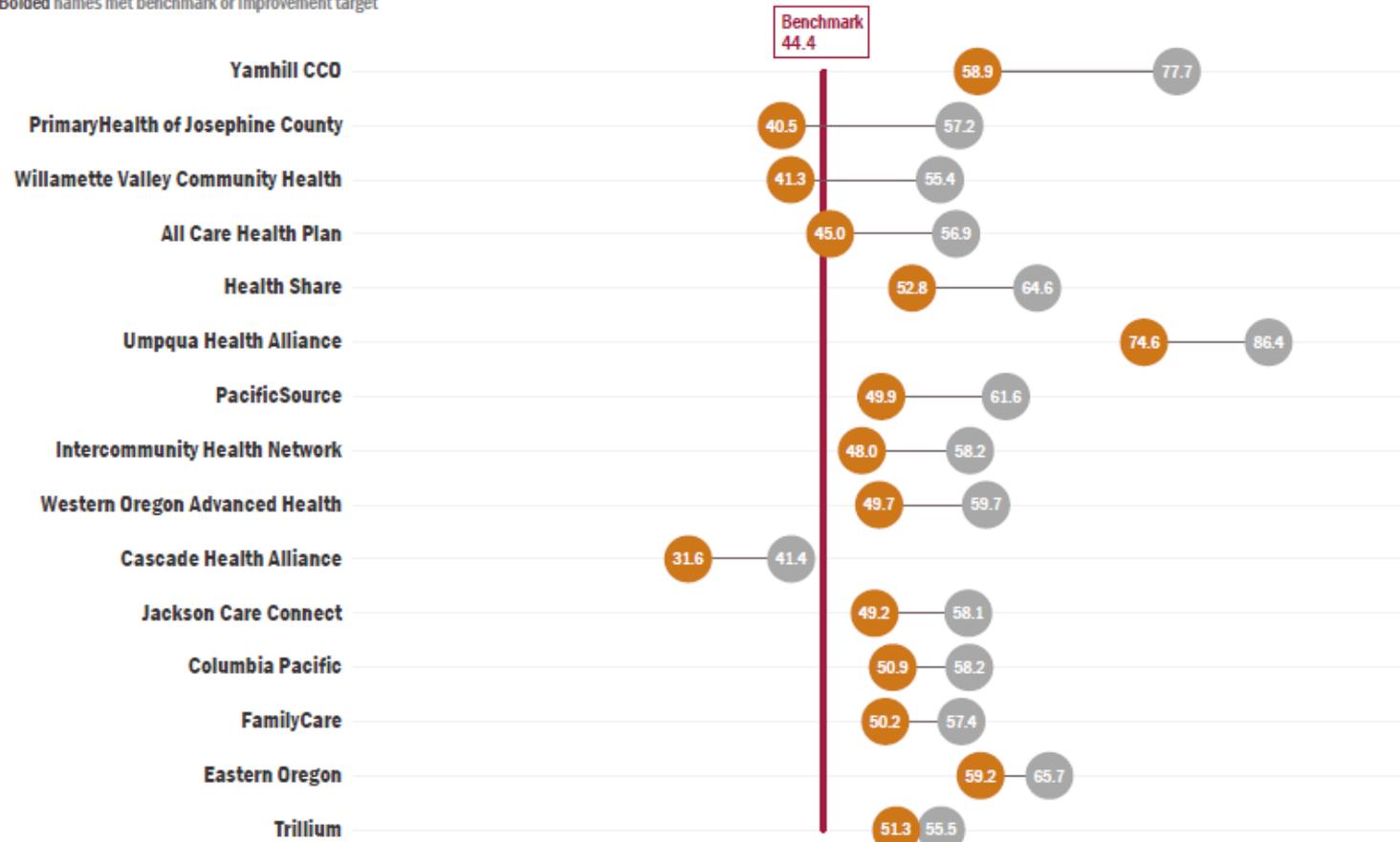


ED utilization by CCO

Rate of patient visits to an emergency department in 2011 & 2013

(Lower scores are better)

Bolded names met benchmark or improvement target



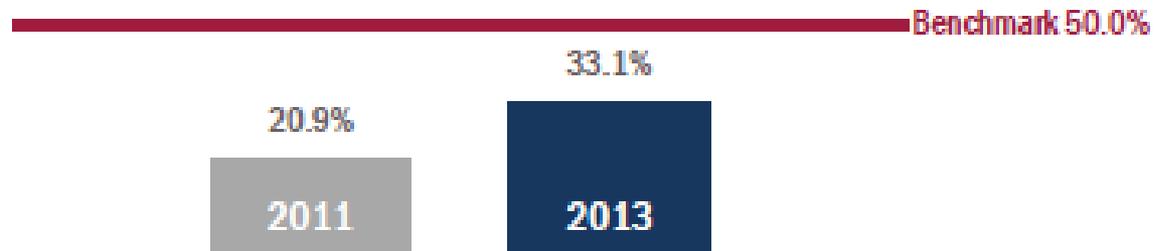
Increased developmental screening

- Developmental screening increased by 58 percent since 2011.

Statewide

Data source: Administrative (billing) claims

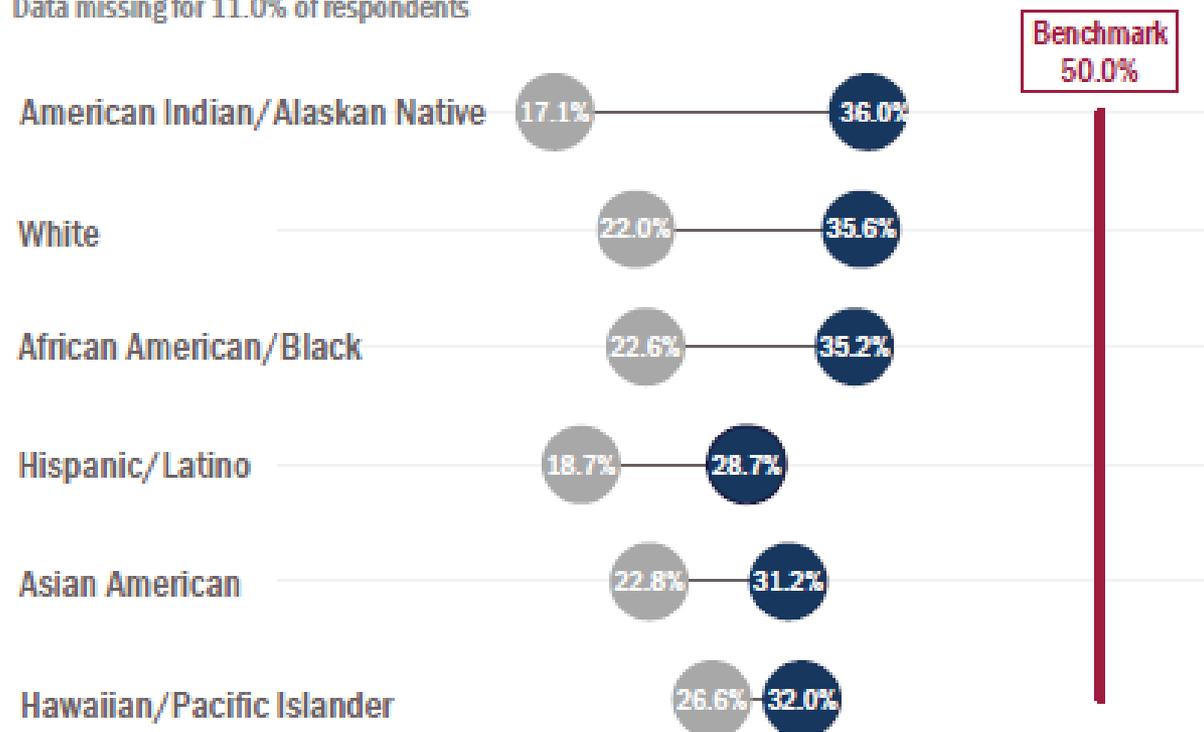
Benchmark source: Metrics and Scoring Committee consensus



Developmental screening by race & ethnicity

Race and ethnicity data between 2011 & 2013

Data missing for 11.0% of respondents



Developmental screening by CCO

Percentage of children up to three-years-old screened for developmental delays in 2011 & 2013

Bolded names met benchmark or improvement target



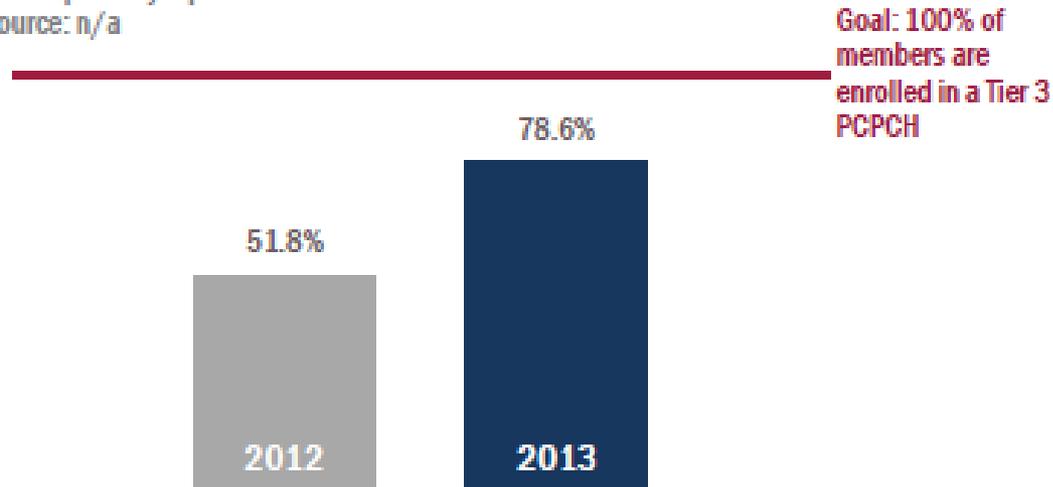
Increased primary care

- Outpatient primary care visits for CCO members' increased by 11%
- Spending for primary care and preventive services are up 20%
- Enrollment in PCPCH has increased by 52% since baseline.

Statewide

Data source: CCO quarterly report

Benchmark source: n/a



PCPCH enrollment by CCO

Percentage of patients who were enrolled in a recognized patient-centered primary care home in 2012 & 2013



Decreased hospitalizations for chronic conditions: congestive heart failure

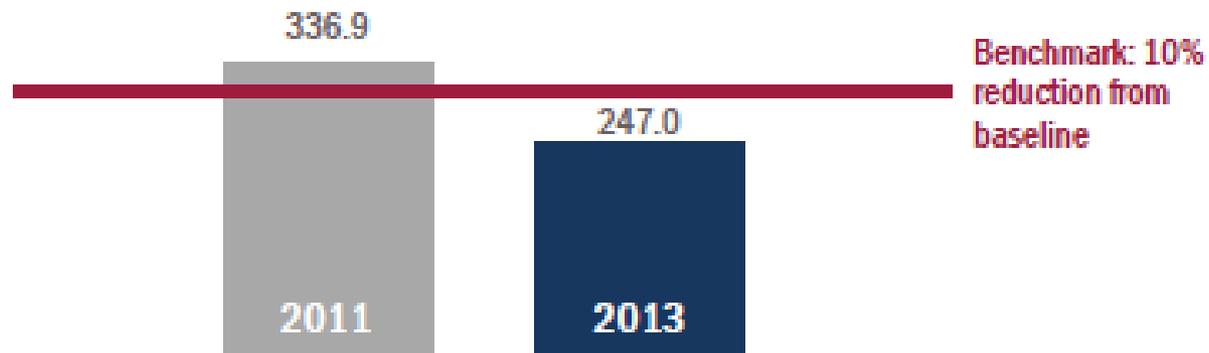
- Admission rate decreased by 27 percent.

Statewide

(Lower scores are better)

Data source: Administrative (billing) claims

Benchmark source: OHA consensus, based on prior performance trend



Decreased hospitalizations for chronic conditions: COPD

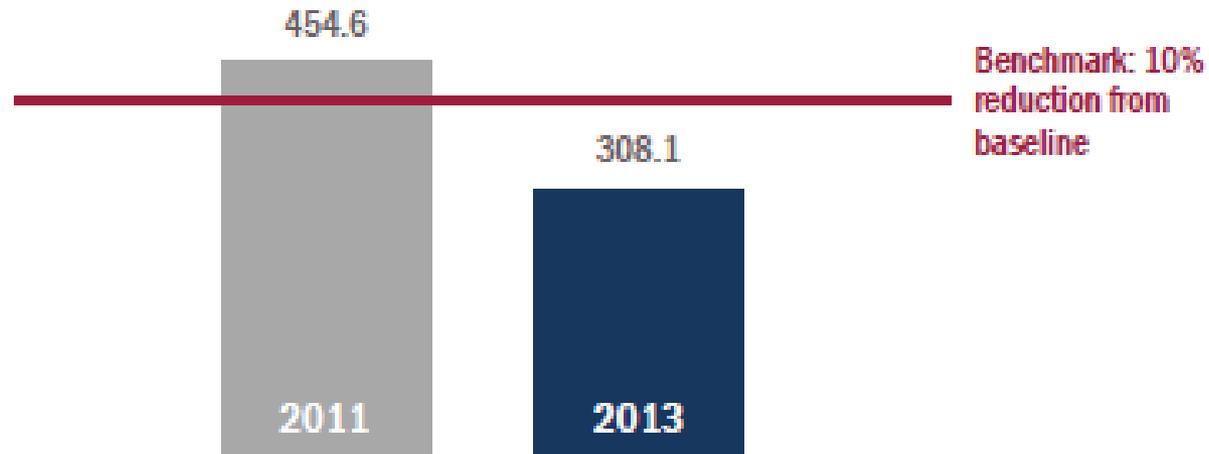
- Admission rate decreased by 32%

Statewide

(Lower scores are better)

Data source: Administrative (billing) claims

Benchmark source: OHA consensus, based on prior performance trend



Decreased hospitalizations for chronic conditions: adult asthma

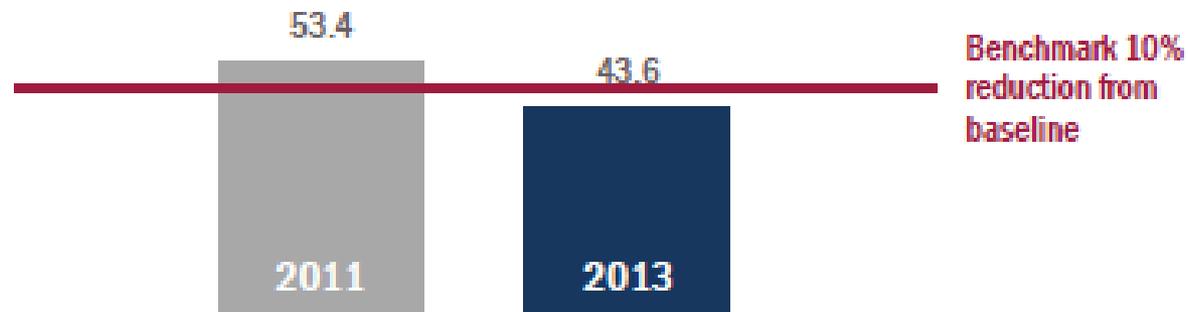
- Admission rate decreased by 18%

Statewide

(Lower scores are better)

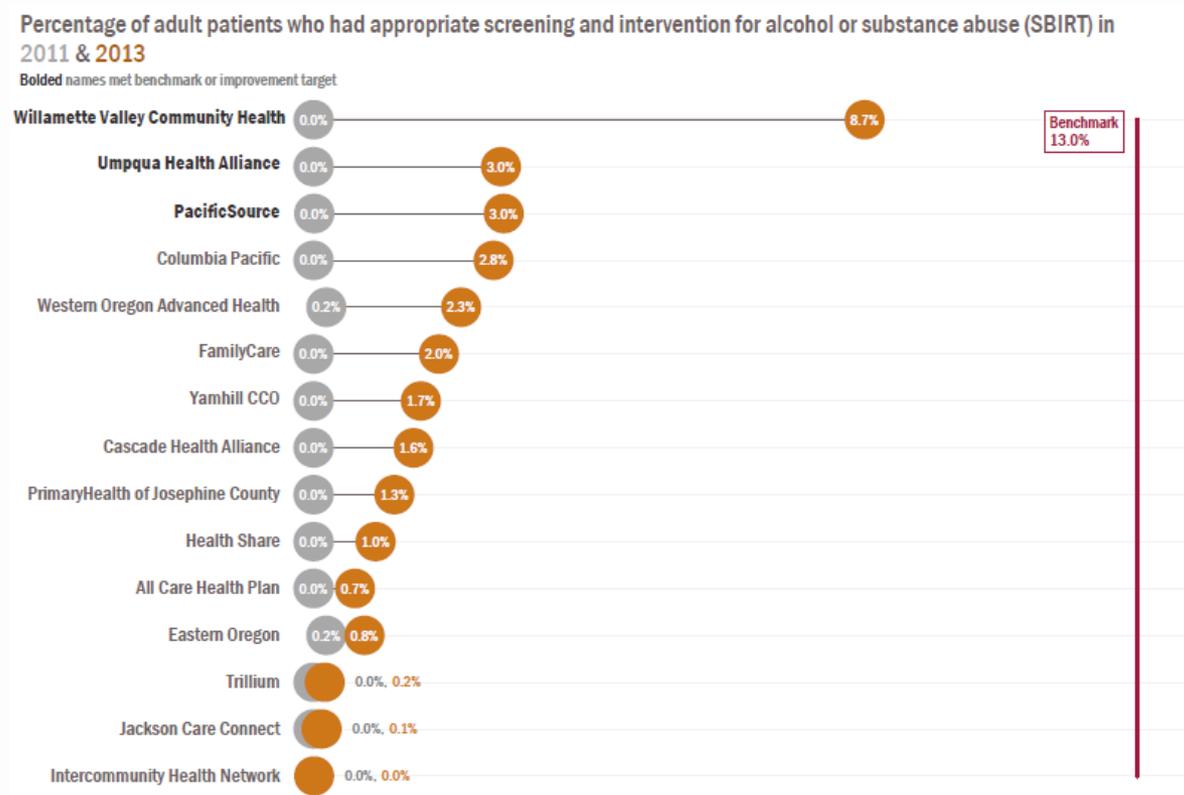
Data source: Administrative (billing) claims

Benchmark source: OHA consensus, based on prior performance trend



Areas for improvement: SBIRT

- Statewide improvement (0.0% → 2.0%)
- Nearly all CCOs made some improvement, but work still needed.



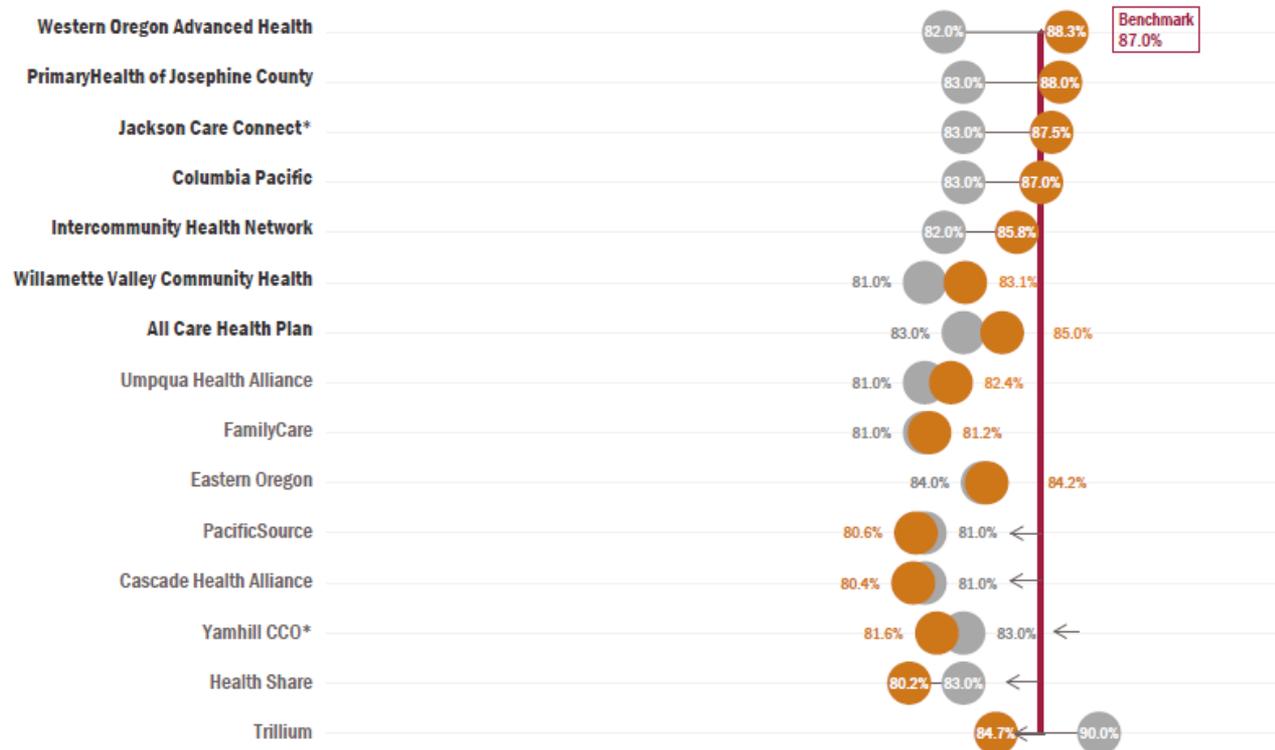
Areas for improvement: Access to care

- Statewide improvement (83% → 84%)
- Seven CCOs met the benchmark or improvement target

Percentage of patients who thought they received appointments and care when needed in 2011 & 2013

Bolded names met benchmark or improvement target

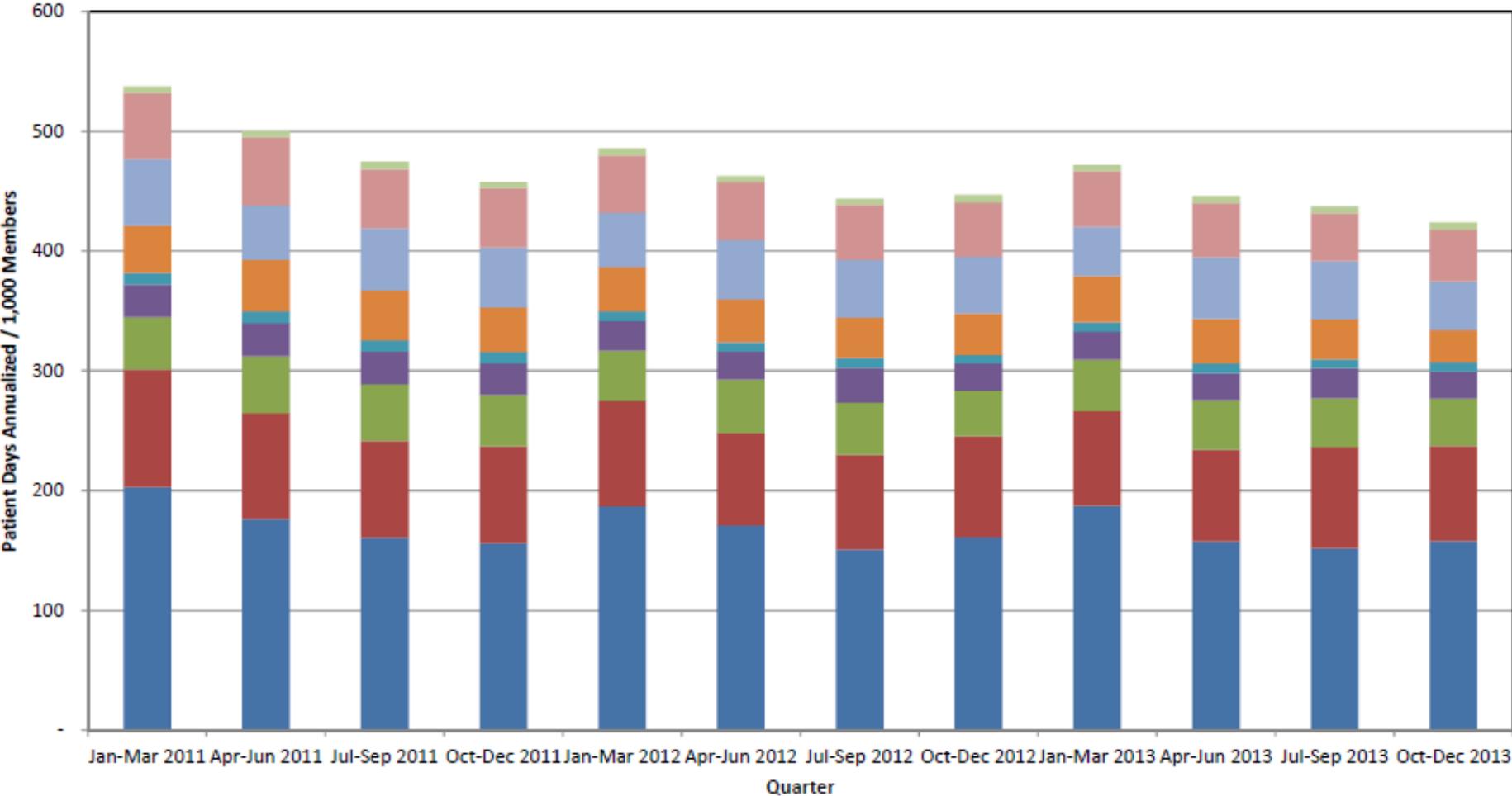
*CCO baseline could not clearly be attributed to a past FCHP. Baseline provided is state average.





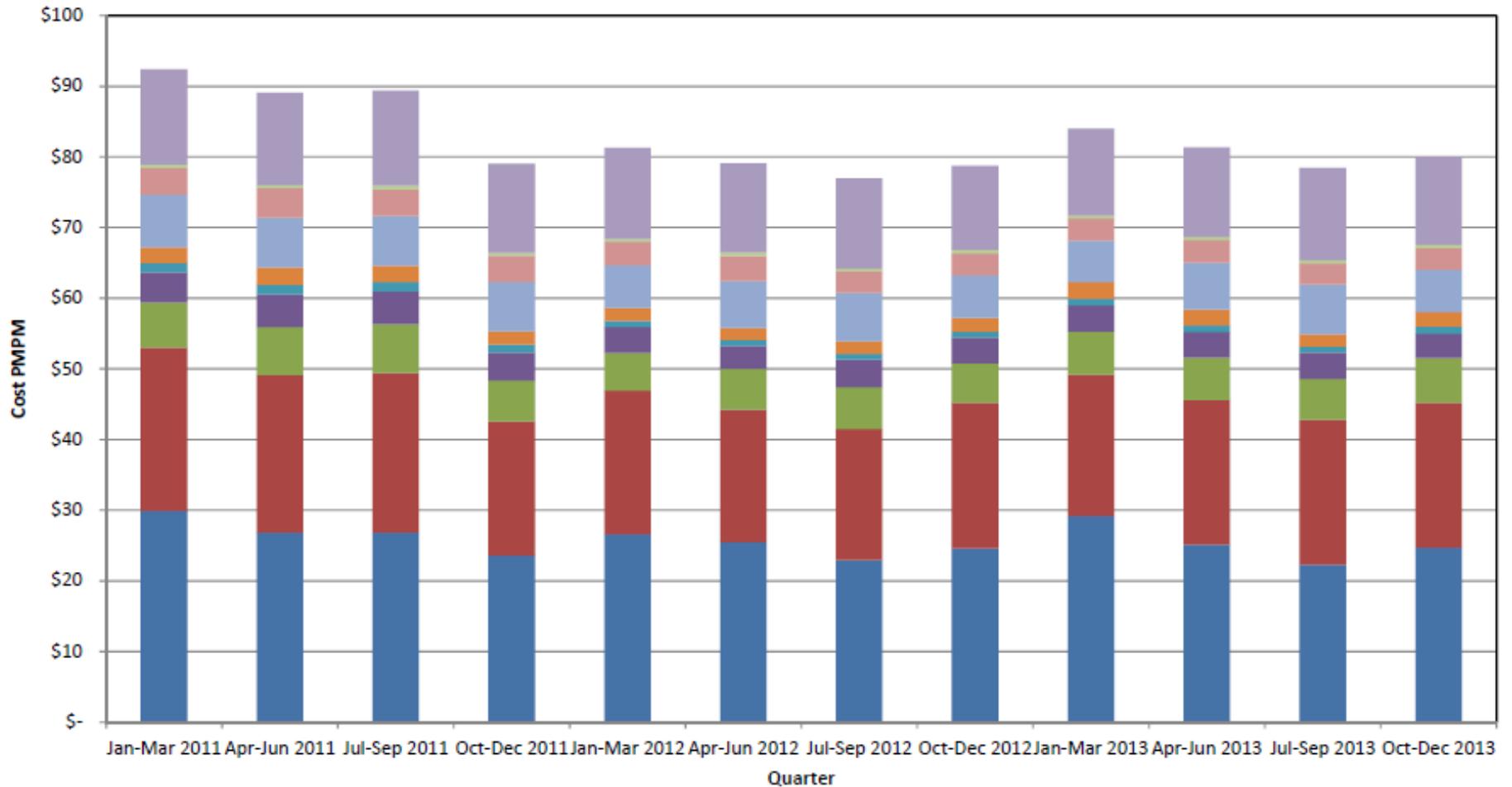
The Big Picture: Cost and Utilization

Inpatient Services -- Patient Days



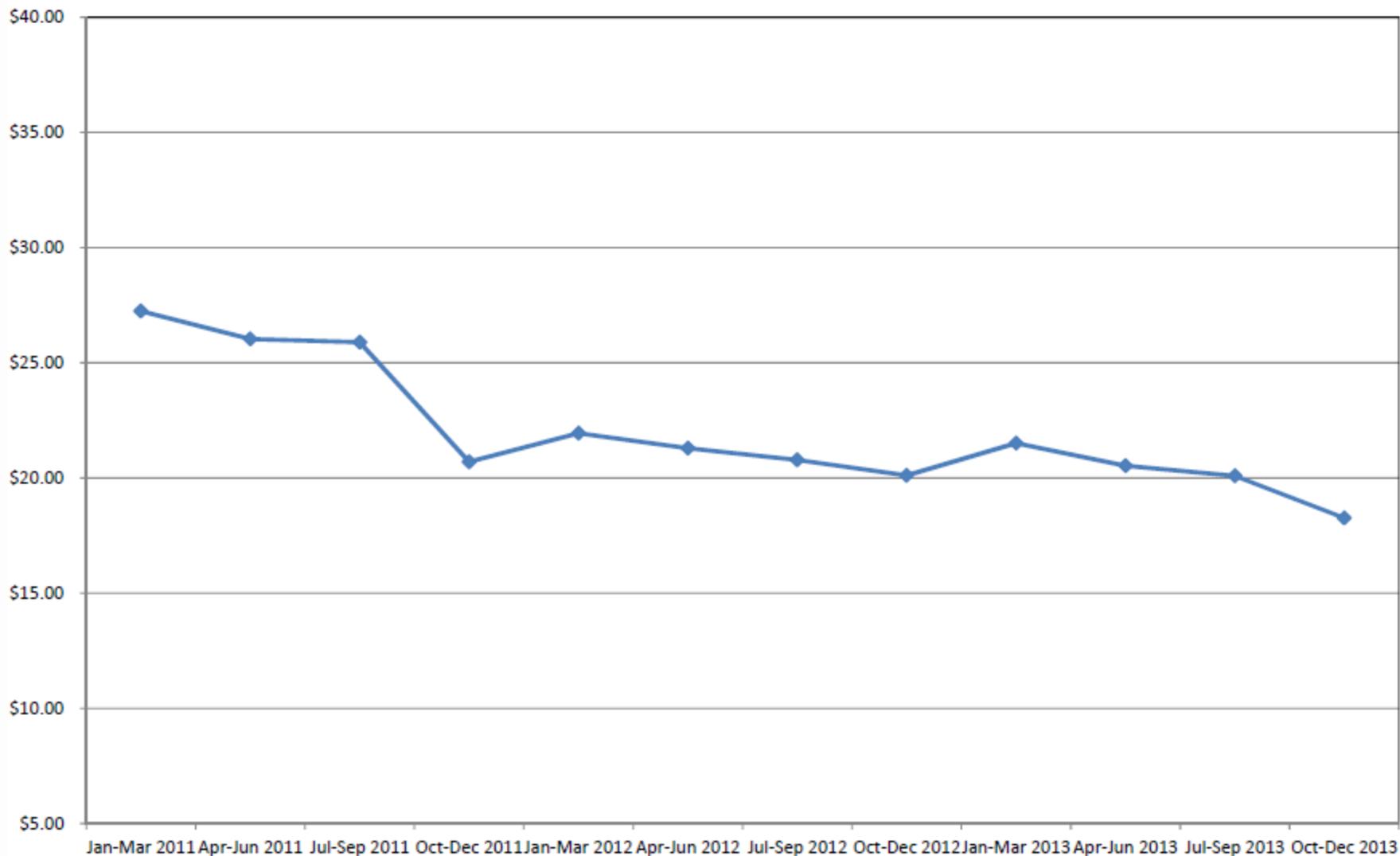
- Inpatient -- Medical / General -- Patient Days
 - Inpatient -- Maternity / Normal Delivery -- Patient Days
 - Inpatient -- Maternity / Non-Delivery -- Patient Days
 - Inpatient -- Newborn / With Complications -- Patient Days
 - Inpatient -- Mental Health / Alcohol and Drug Abuse -- Patient Days
- Inpatient -- Surgical -- Patient Days
 - Inpatient -- Maternity / C-Section Delivery -- Patient Days
 - Inpatient -- Newborn / Well -- Patient Days
 - Inpatient -- Mental Health / Psychiatric -- Patient Days

Inpatient Services -- PMPM



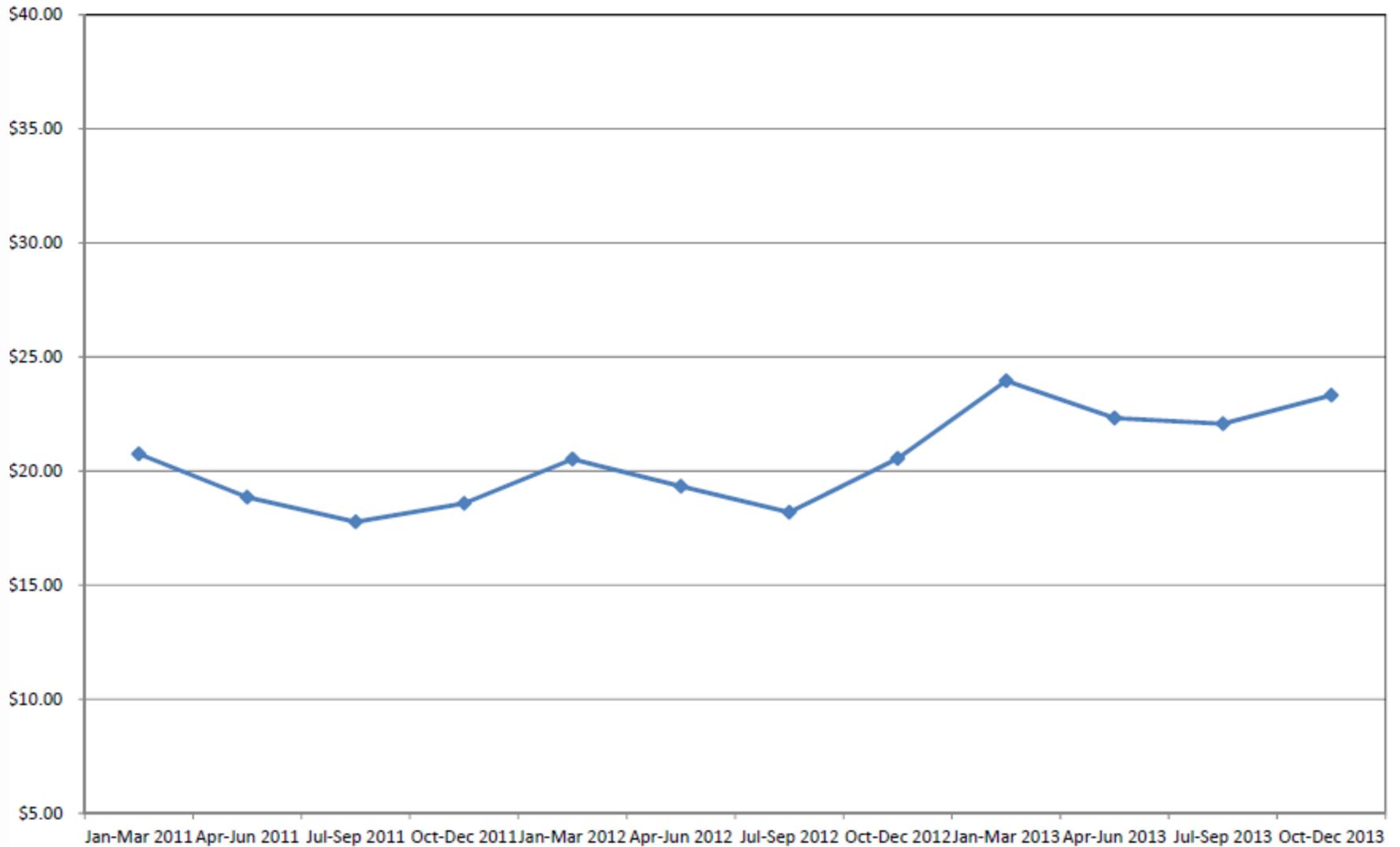
- Inpatient -- Medical / General
- Inpatient -- Surgical
- Inpatient -- Maternity / Normal Delivery
- Inpatient -- Maternity / C-Section Delivery
- Inpatient -- Maternity / Non-Delivery
- Inpatient -- Newborn / Well
- Inpatient -- Newborn / With Complications
- Inpatient -- Mental Health / Psychiatric
- Inpatient -- Mental Health / Alcohol and Drug Abuse
- Inpatient -- Physician Services

Emergency Costs (Professional and Technical) -- PMPM



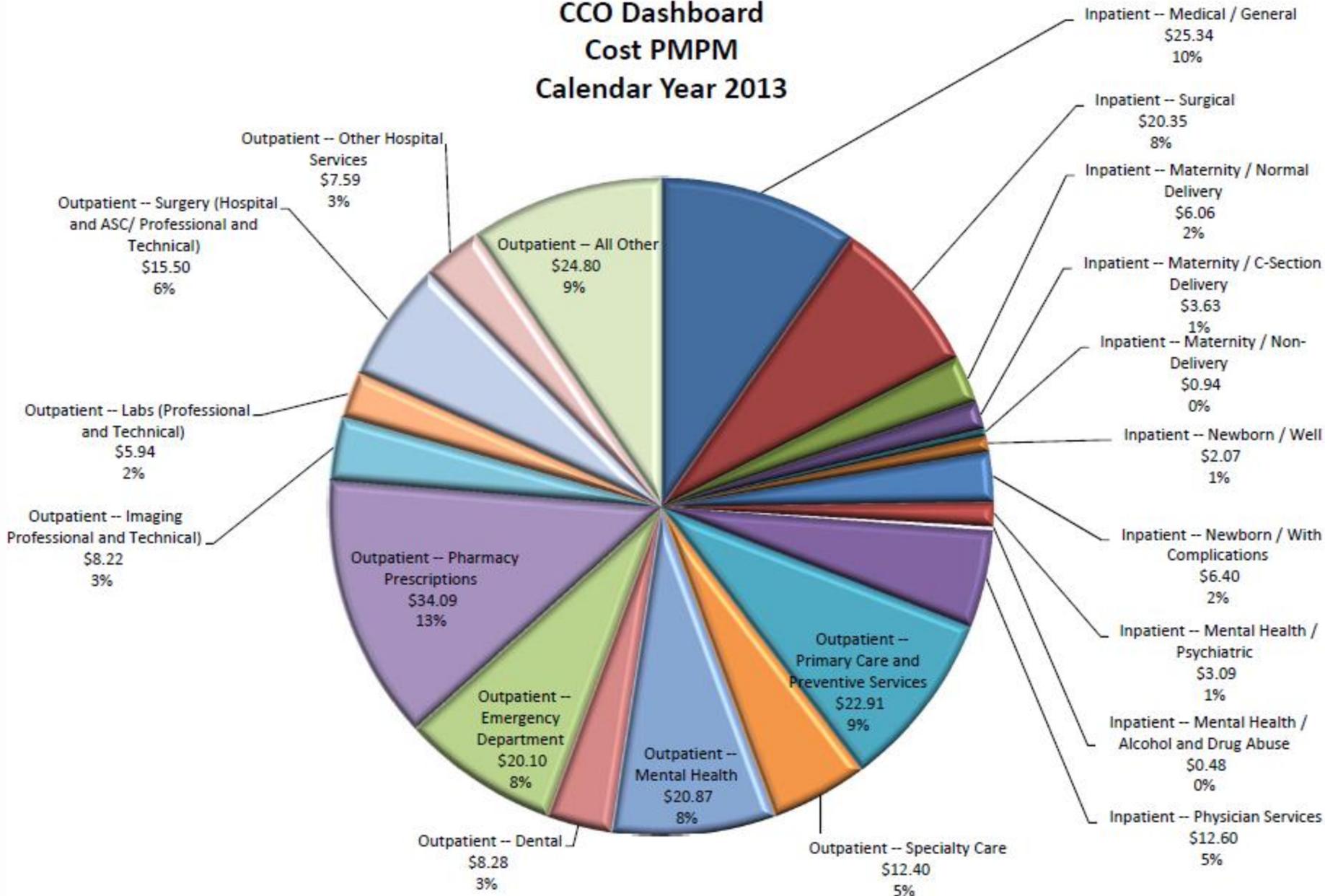
—◆— Outpatient -- Emergency Department (Professional and Technical)

Primary Care Costs -- PMPM



◆ Outpatient -- Primary Care and Preventive Services

CCO Dashboard Cost PMPM Calendar Year 2013



Next steps

- Continue to report at state and CCO level.
- Roll in 2014 data to monitor expansion population.
- Provide CCOs with CY 2013 data by race and ethnicity at CCO level (August learning collaborative).
- Continue subpopulation analysis of 2013 data (measures by language, by disability, etc)



For more information

The 2013 performance report and all technical specifications are posted online at health.oregon.gov

Contact

Lori Coyner, MA

Director of Health Analytics

lori.a.coyner@state.or.us

Public Employees' Benefit Board 2015 Medical Plans

Oregon Health Policy Board
July 1, 2014

Kelly Ballas, CFO
Oregon Health Authority



Request for Proposal

- PEBB released a request for proposal Oct. 2, 2013
- Received responses from 11 vendors by Nov. 22, 2013 close
- Accepted proposals for statewide, regional, medical only, pharmacy only, medical & pharmacy
- RFP included questions regarding better health, better care and lower cost
- All responses were reviewed by board members and interim administrator
- Some sections, such as implementation plans, were reviewed by PEBB and Mercer staff



Selection of Apparent Successful Proposers

- Board had stated goal of choice in as many areas of the state as possible
- Divided the state into regions for the purpose of selecting vendors
- RFP allowed for up to one statewide plan and multiple regional plans
- Selected the highest scoring statewide plan: self-insured plan administered by Providence
- Selected multiple regional plans resulting in 97% of employees having more than one plan choice in their county



3

Contracting with Vendors

- Contracts have been signed with all Apparent Successful Proposers:
 - Kaiser (fully insured regional plan)
 - Mid-Rogue CCO (fully insured regional plan)
 - Moda (two fully insured regional CCO model plan)
 - Providence (self insured statewide and regional plans)
 - Trillium (self insured regional CCO model plan)
- Administrative performance guarantees with penalties are in force for 2015
- Baseline CCO metric data will be gathered in 2015
- Penalties / Bonuses will be attached to metrics in 2016
- A list of vendors by county is attached



4

Contracting with Vendors

- Contracts include support of Healthcare Reform and Transformation, including:
 - Increasing the number of Patient-Centered Primary Care Homes in Network
 - Make reasonable efforts to increase utilization of electronic medical records
 - Not reimbursing facilities for hospital acquired conditions
 - Actively participating in the Oregon Healthcare Quality Corporations Aligning Forces for Quality
 - Make reasonable efforts to require contracted hospitals to increase cost transparency
 - Engage in efforts to reduce hospital readmissions
 - Submit claims to the All Payer All Claims data base
 - Participate in administrative simplification efforts



5

Contracting with Vendors

- Other reports:
 - Report PEBB-specific HEDIS measures
 - Drug utilization data
 - Care integration
 - Maternity / newborn care
 - Substance abuse and mental health treatment
 - Member satisfaction
 - 42 performance measures, CCO metrics plus PEBB specific (attached)



6

Cost

- Medical premium rates are stable
- PEBB's budget rate for 2015 is 0.09% lower than 2014



7

Plans by County

(plans with lowest premiums in county are highlighted)

	Oregon Counties							
	Kaiser Permanente	Kaiser Deductible	Moda Summit	Moda Synergy	Mid Rogue	PEBB Statewide	Providence Choice	Trillium
Baker			X			X	X	
Benton	X	X		X		X	X	
Clackamas	X	X		X		X	X	
Clatsop						X		
Columbia	X	X				X		
Coos						X	X	
Crook						X	X	
Curry					X	X	X	
Deschutes						X	X	
Douglas						X	X	
Gilliam			X			X		
Grant			X			X		
Harney			X			X		
Hood River	X	X				X	X	
Jackson					X	X	X	
Jefferson						X	X	
Josephine					X	X	X	
Klamath						X	X	



8

Plans by County

(plans with lowest premiums in county are highlighted)

Oregon Counties								
	Kaiser Permanente	Kaiser Deductible	Moda Summit	Moda Synergy	Mid Rogue	PEBB Statewide	Providence Choice	Trillium
Lake			X			X		
Lane				X		X	X	X
Lincoln						X	X	
Linn	X	X		X		X	X	
Malheur			X			X	X	
Marion	X	X		X		X	X	
Morrow			X			X		
Multnomah	X	X		X		X	X	
Polk	X	X		X		X	X	
Sherman			X			X		
Tillamook						X		
Umatilla			X			X	X	
Union			X			X	X	
Wallowa			X			X	X	
Wasco						X		
Washington	X	X		X		X	X	
Wheeler			X			X		
Yamhill	X	X		X		X	X	



Plans by County

(plans with lowest premiums in county are highlighted)

Idaho and Washington Counties							
	Kaiser Permanente	Kaiser Deductible	Moda Summit	Moda Synergy	Mid Rogue	PEBB Statewide	Providence Choice
Payette			X			X	X
Clark	X	X		X		X	X
Cowlitz	X	X				X	
Lewis	X	X				X	
Skamania	X	X				X	
Wahkiakum	X	X				X	
Walla Walla						X	X



2015 Performance Measures

Alcohol or other substance misuse (SBIRT)
 Follow-up after hospitalization for mental illness (NQF 0576)
 Screening for clinical depression and follow-up plan (NQF 0418)
 Follow-up care for children prescribed ADHD meds (NQF 0108)
 Prenatal and postpartum care: Timeliness of Prenatal Care (NQF 1517)
 PC-01: Elective delivery before 39 weeks (NQF 0469)
 Ambulatory Care: Outpatient and Emergency Department utilization
 Colorectal cancer screening (HEDIS)
 Patient-Centered Primary Care Home Enrollment
 Developmental screening in the first 36 months of life (NQF 1448)
 Adolescent well-care visits (NCQA)
 Controlling high blood pressure (NQF 0018)
 Diabetes: HbA1c Poor Control (NQF 0059)
 CAHPS adult and child composites: Access to care
 CAHPS adult and child composites: Satisfaction with care
 EHR adoption
 Prenatal and postpartum care: Postpartum Care Rate (NQF 1517)
 Plan all-cause readmission (NQF 1768)
 Well-child visits in the first 15 months of life (NQF 1392)
 Childhood immunization status (NQF 0038)
 Immunization for adolescents (NQF 1407)



11



2015 Performance Measures

Appropriate testing for children with pharyngitis (NQF 0002)
 Medical assistance with smoking and tobacco use cessation (CAHPS) (NQF 0027)
 Comprehensive diabetes care: LDL-C Screening (NQF 0063)
 Comprehensive diabetes care: Hemoglobin A1c testing (NQF 0057)
 PQI 01: Diabetes, short term complication admission rate (NQF 0272)
 PQI 05: Chronic obstructive pulmonary disease admission (NQF 0275)
 PQI 08: Congestive heart failure admission rate (NQF 0277)
 PQI 15: Adult asthma admission rate (NQF 0283)
 Chlamydia screening in women ages 16-24 (NQF 0033)
 Cervical cancer screening (NQF 0032)
 Child and adolescent access to primary care practitioners (NCQA)
 Adult BMI Assessment (HEDIS)
 Weight Assessment in children/adolescents (HEDIS)
 Counseling for Nutrition in children/adolescents (HEDIS)
 Counseling for Physical Activity in children/adolescents (HEDIS)
 Average BMI
 Percentage of PEBB members with BMI categorized as overweight
 Percentage of PEBB members with BMI categorized as obese
 Percentage of PEBB members that currently use tobacco
 Comprehensive Diabetes Care: Eye Exams
 Comprehensive Diabetes Care: Nephropathy Assessment

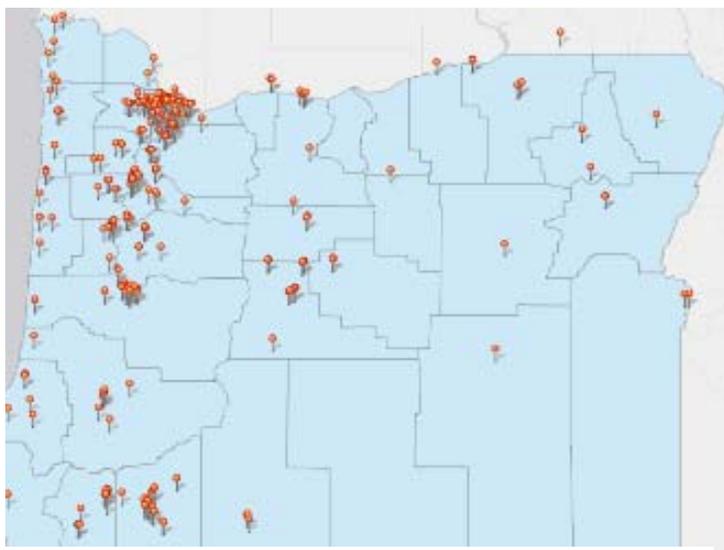


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Patient-Centered Primary Care Home Program

Patient-Centered Primary Care Homes (PCPCHs) are health care clinics that have been recognized by the Oregon Health Authority for their commitment to providing high quality, patient-centered care. At its heart, this model of care fosters strong relationships with patients and their families to better treat the whole person. Primary care homes reduce costs and improve care by catching problems early, focusing on prevention, wellness and management of chronic conditions.



Map of Recognized PCPCHs (as of June 2014)

PCPCH Program Facts

- More than 500 clinics across Oregon have been recognized by the Oregon Health Authority as primary care homes. There are recognized PCPCHs in 33 out of 36 counties in Oregon.
- Through our partnership with Quality Corporation, the Patient-Centered Primary Care Institute is advancing practice transformation state-wide through technical assistance opportunities and resources.
- Over 50 PCPCHs have received on-site verification visits. The site visits create an opportunity to collaborate with clinics and identify needs, barriers and areas of improvement.

Key Attributes for PCPCH recognition

- **Accessible:** Care is available when patients need it.
- **Accountable:** Clinics take responsibility for the population and community they serve and provide quality, evidence-based care.
- **Comprehensive:** Patients get the care, information and services they need to stay healthy.
- **Continuity:** Providers know their patients and work with them to improve their health over time.
- **Coordinated:** Care is integrated and clinics help patients navigate the health care system to get the care they need in a safe and timely way.
- **Patient & Family Centered:** Individuals and families are the most important part of a patient's health care. Care should draw on a patient's strengths to set goals and communication should be culturally competent and understandable for all.



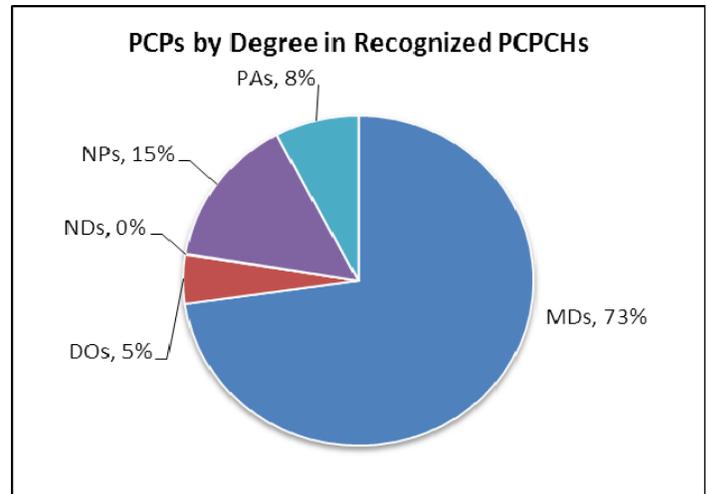
www.PrimaryCareHome.oregon.gov

Email PCPCH@state.or.us

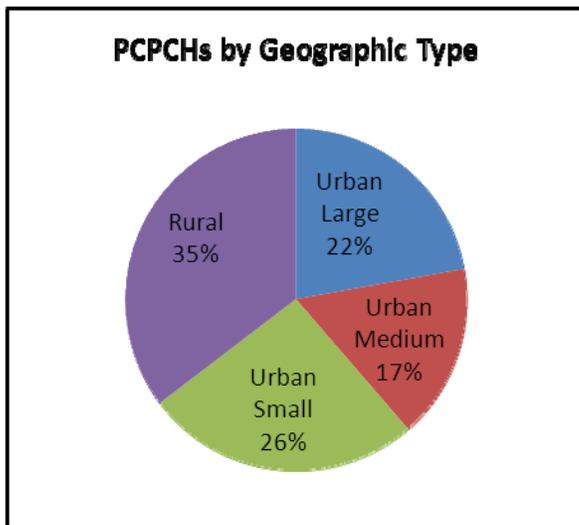
Patient-Centered Primary Care Home Program

Characteristics of PCPCHs

- Over 2,500 primary care providers serve patients at PCPCHs
- Average number of providers = 5.1 FTEs
- Average number of other clinic staff = 9.4 FTEs
- The majority of practices serve adult and pediatric populations
- Less than 20% of practices offer complementary and alternative medicine
- Over 80% of PCPCHs surveyed initiated a new service or program directly related to the implementation of the PCPCH model



Source: Oregon Health Care Quality Corporation Provider Directory (Jan 2013)



Source: PCPCH Supplemental Survey (June 2013)

PCPCHs and CCOs

PCPCHs are at the heart of Oregon's health system transformation efforts. Coordinated Care Organizations (CCOs) are required to include PCPCHs in their networks of care to the extent possible. Expanding the availability of primary care homes will provide better access to care now and strengthen the primary care networks as CCOs emerge. Over 500,000 CCO members (over 75% of the total CCO population) already receive care at a primary care home. This number is expected to grow over time.

PCPCHs and the Triple Aim

Oregon implemented the PCPCH program as part of the state's strategy to achieve the Triple Aim of improving the individual experience of care, improving population health management and decreasing the cost of care.

- Significantly lower rates for specialty office visits, radiology, and emergency department use as well as lower total expenditures were demonstrated by PCPCH patients as compared to those seeking care in non-recognized clinics.
- 85% of practices surveyed report that PCPCH implementation is helping them improve individual experience of care.
- 82% of practices report that PCPCH implementation is helping them improve population health management.
- 85% of practices report that PCPCH implementation is helping them increase the quality of care provided.

www.PrimaryCareHome.oregon.gov

Email PCPCH@state.or.us

Strengthening & monitoring primary care system infrastructure and investment

Oregon Health Policy Board Discussion
July 2014

Nicole Merrithew, PCPCH Program Director
Lisa Angus, OHPB



Topics for discussion

- PCPCH program update
- Environmental scan & preliminary assessment of strategies for advancing and measuring primary care infrastructure and investment
 - *Board input on promising strategies*
- Potential next steps



Patient-Centered Primary Care Home Program

HB 2009 established the PCPCH Program:

Create access to patient-centered, high quality care and reduce costs by supporting practice transformation

Key PCPCH program functions:

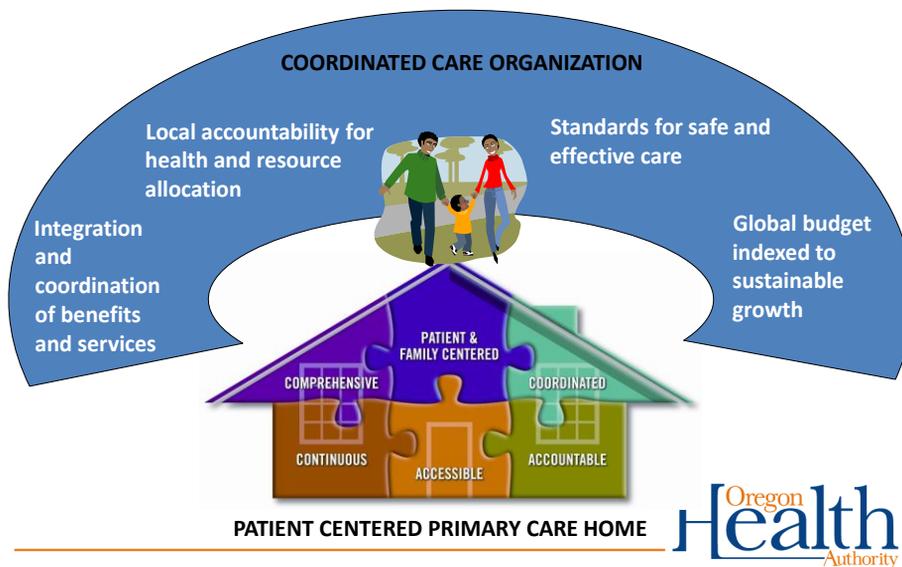
- PCPCH recognition and verification
- Refinement and evaluation of the PCPCH standards
- Technical assistance development
- Communication and provider engagement

Goals:

- All OHA covered lives receive care through a PCPCH
- 75% of all Oregonians have access to a PCPCH by 2015
- Align primary care transformation efforts by spreading the model to payers outside the OHA

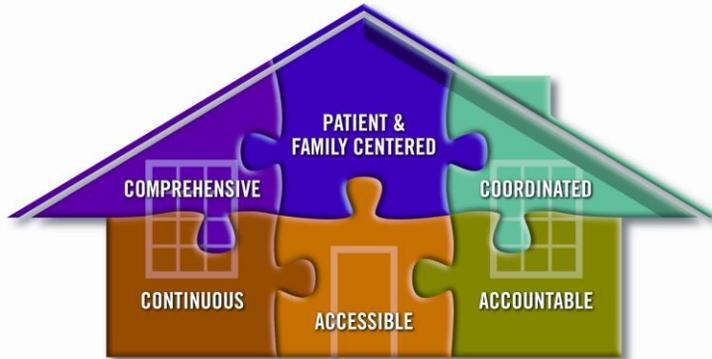


Health System Transformation

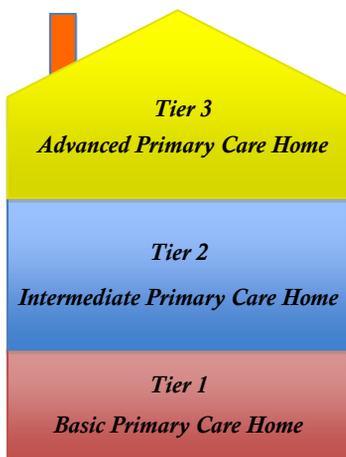


Core Attributes of a Primary Care Home

Oregon's PCPCH model is defined by six core attributes, each with specific standards and measures



Different Levels of Primary Care "Home-ness"



- Proactive patient and population management
- Accountable for quality and utilization
- 130 + points and all 10 must-pass criteria

- Demonstrates performance improvement
- Additional structure and process improvements
- 65 - 125 points and all 10 must-pass criteria

- Foundational structures and processes
- 30 – 60 points and all 10 must-pass criteria



Summary of 2014 Standards

- 10 must-pass standards are the same
- More options available for clinics to achieve PCPCH recognition
- Provides a road map for transformation
- Enhanced focus on continuous quality improvement structure and culture
- Enhanced focus on demonstrating improvement
- Encourages greater involvement of patients/families/caregivers/advisors

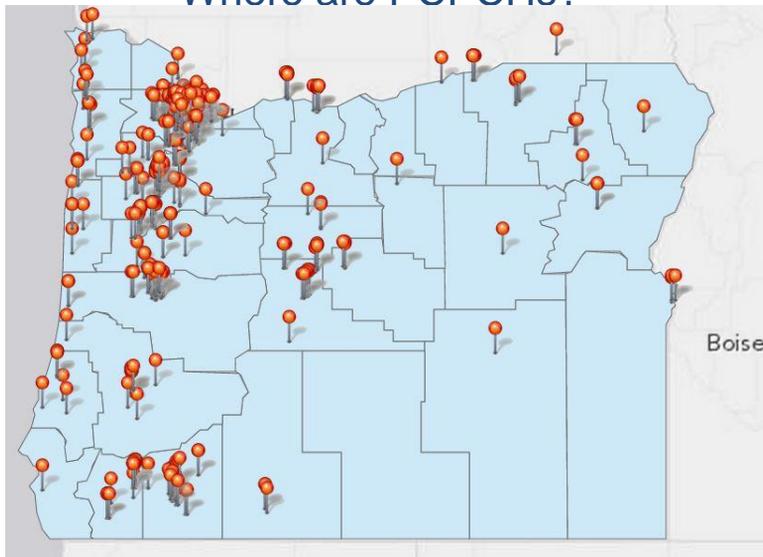


Verification Site Visits

- Launched in September 2012
- Conducted more than 50 site visits to-date
- Goals:
 - **Verification** that the clinic practice and patient experience in the practice accurately reflects the Standards and Measures attested to on their PCPCH recognition application.
 - **Assessment** of the care delivery and team transformation process to understand how the intent of the patient-centered care model is integrated into the qualities and services of the PCPCH.
 - **Collaboration** to identify needs/barriers/areas of improvement to help clinics establish improvement plans, and to connect clinics with colleague and technical assistance through the [Patient-Centered Primary Care Institute](#)



Where are PCPCHs?



Oregon
Health
Authority

What do PCPCHs look like?

- Staffing
 - Average # providers = 5.1 (1-39 FTE)
 - Average # other clinical staff = 9.4 (0-70 FTE)
 - Average # annual visits = 14,539 (229-134,000)
- Services
 - Majority serve adult and pediatric populations
 - Majority provide obstetrics care
 - < 20% offer CAM
- Ownership
 - Nearly half owned by a larger system
 - 40% independent and unaffiliated
 - About 10% independent but in alliances

Oregon
Health
Authority

What we have learned?

- Implementation
 - Over 80% (N=252) of survey respondents needed to add new services in order to implement the model
- Achieving the Triple Aim
 - 85% of those surveyed believe the PCPCH model is helping them improve the individual experience of care
 - 85% feel the model is helping their practice increase the quality of care
 - 82% report the model is helping them improve population health management



What have we learned?

- Improving access and outcomes
 - 75% feel the model is helping their practice increase access to services
 - PCPCH clinics demonstrated significantly higher mean scores than non-PCPCH clinics for diabetes eye exams, kidney disease monitoring in diabetics, appropriate use of antibiotics for children with pharyngitis, and well-child visits for children ages three to six years (*Information for a Healthy Oregon*. The Quality Corporation, August 2013.)
- Utilization and cost
 - Significantly lower ED and specialty utilization as well as total cost for PCPCHs as compared to non-recognized clinics



Alignment With Selected Demonstration Outcomes

Blue Cross Blue Shield of Michigan Physician Group Incentive Program (Commercial):

- Enhanced reimbursement and incentive pool funds for designated PCMH providers
 - 10% fewer ED visits among adults
 - 17% fewer ambulatory care sensitive inpatient admissions
 - Overall health care cost savings of \$26.37 PMPM

Oklahoma SoonerCare (Medicaid):

- PMPM Care Coordination fee plus performance-based incentives
 - Cost savings of \$29 PMPM

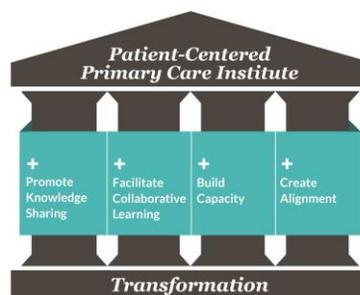
Vermont Blueprint for Health (Multi-payer):

- PMPM fee to PCMH practices based on NCQA PCMH points earned; multi-payer funded community health teams
 - 27% reduction in projected cost avoidance across its commercial insurer population
 - 31% reduction in emergency department utilization



Patient-Centered Primary Care Institute

- Launched in 2012
- Public-private partnership
- Broad array of technical assistance for practices at all stages of transformation
 - Learning Collaboratives
 - Website (www.pccpci.org)
 - Webinars & Online Learning
- Ongoing mechanism to support practice transformation and quality improvement in Oregon



What do practices still need?

- Most commonly reported barriers:
 - Cost and lack of resources
 - Staffing and training
 - Time
 - Administrative burden and reporting
- Most requested areas for future assistance:
 - Patient and family engagement and communication
 - Behavioral health integration
 - Care management/complex case management
 - Comprehensive care planning
 - Care coordination
 - Team-based care and empanelment



Where PCPCH Program Is Headed

- Communication and Engagement
 - Maintain relationships with engaged clinics
 - Engage unrecognized clinics
 - Approximately 400 – 500 unrecognized clinics in Oregon
 - Partnerships with other organization and stakeholders for identification and connection
- Technical Assistance
 - Expanded site visit process & technical assistance support
 - Two teams that include practice coach and clinical champion
 - Follow-up and assistance with setting/achieving goals



Questions?

Strengthening PC infrastructure & investment – why now?

- OHPB 2013 recommendation and 2014 deliverable to identify strategies to support PC infrastructure
- Primary care at the heart of health system transformation
- Many groups across the state engaged in primary care payment and delivery system reform; high level of activity may be outpacing dedicated infrastructure support

Strategy Development

- Broad scan of promising strategies for advancing and measuring multi-payer investment in Oregon's primary care system, conducted by national expert organizations (CHCS and SHADAC).
- Four kinds of policy strategies highlighted
 1. Multi-payer PC infrastructure investment
 2. PC Revenue enhancement
 3. Support for practice transformation
 4. Primary care workforce enhancements



STRATEGY 1: Multi-payer infrastructure investment

What: Mechanisms to boost multi-payer investment and/or endure broad participation in primary care transformation.

Examples: Legislation to create & enforce PC investment or medical home initiatives (VT, MD, MN, others)

Evidence & impact: High potential impact; significant effort to initially establish



STRATEGY 1: Oregon activity & gaps

Activity:

- Voluntary multi-payer agreement to financially support PCPCH model
- PCPCH payments
 - ACA Health Home payments (ended Oct. 2013); PEBB; Aetna; some CCOs; reports of other primary care APMs being tested or in place
- Comprehensive Primary Care Initiative (ends 2016)
- CCO incentive measure around PCPCH enrollment

Gaps:

- Multi-payer agreement does not guarantee follow-through
- Difficult to specifically assess degree of spread
- Amount of current PCPCH payments varies widely
- CCO metric does not guarantee funding goes to providers
- CPC initiative is time-limited



STRATEGY 2: Primary care revenue enhancement

What: Voluntary or mandated action by payers to increase and/or reform payments for PC services or to PC providers broadly.

Examples: ACA primary care payment bump; wide range of public and private example of primary-care focused P4P, shared savings, or other alternative payment schemes.

Evidence & impact: Heavily dependent on scale and cross-market alignment



STRATEGY 2: Oregon activity & gaps

Activity:

- ACA primary care payment bump through 2014
- NP & PA primary care payment parity bill from 2013 (HB 2902; sunsets end of 2017)

Gaps:

- Current activity is time-limited
- Does not necessarily align with health system transformation and/or movement away from a FFS system



STRATEGY 3: Support for practice transformation

What: Financial and non-financial support to assist PC practices and providers to change the model of care.

Examples: Start-up funding for HIT tools, new staff, or other infrastructure; practice facilitation and/or primary care “extension” programs

Evidence & impact: Good evidence for impact; scale-up and dissemination can be challenging



STRATEGY 3: Oregon activity & gaps

Activity:

- PCPCI and transformation center (clinical innovators)
- New practice facilitation and site visitor staff in PCPCH program
- CPC and other learning collaboratives
- Individual efforts through local TA providers (i.e. ORPRN, OPIP, OPCA, and others)

Gaps:

- Current activity is time/resource-limited and/or exclusive to particular providers



STRATEGY 4: Enhance PC workforce

What: Training and regulatory mechanisms to increase supply or expand capacity of those delivering primary care

Examples: Multi-payer investment in primary care graduate medical education; incentives to encourage providers to practice in primary care disciplines; re-training of clinical workforce

Evidence & impact: Good potential for impact; many workforce strategies are medium- or long-term for return



STRATEGY 4: Oregon activity & gaps

Activity:

- Two reports coming to OHPB in August:
 1. Options for increasing primary care medical residencies in Oregon
 2. Recommendations for aligning and targeting incentive programs designed to recruit & retain primary care providers
- Efforts across the state to develop new workforce (e.g. THWs) or use existing workforce in new ways

Gaps:

- Difficult to train or re-train workforce while model of care is still developing



Preliminary thoughts: promising strategies for Oregon today

- Formalize multi-payer collaborative in statute; direct group to design initiative in which payers:
 - Pilot a uniform primary care payment (PMPM to PCPCHs; comprehensive PC capitation rate, or similar) and develop benchmarks for success that would trigger continuation of initiative past pilot phase
 - Make equitable investments in PC transformation assistance
- Invest in graduate medical education
- Incorporate re-training for primary care workforce into transformation assistance



Questions and feedback?

Measurement options

- Expert organizations made suggestions of metrics to monitor:
 - The impact of policies to enhance primary care infrastructure (e.g. # of primary care providers in Oregon or % of CCO enrollees in enrolled in PCPCHs); and
 - Performance of the primary care system (e.g. primary care visits/1,000 population, ambulatory care sensitive admissions)
- Many recommended measures already being tracked by OHA via the PCPCH program, CCO and multi-payer dashboards, and workforce reporting

Closing measurement gaps

- Measures of PC payment transformation and level of investment seem most needed, such as:
 - Primary care as proportion of total spending (over time and by payer)
 - Percent of primary care spending that is not FFS (over time and by payer)
- Also workforce and evaluative measures, e.g.
 - Retention rate of primary care trainees in Oregon
 - Utilization and spending for enrollees in PCPCHs vs. not



Next Steps

- Further development and stakeholder consultation on strategies the Board wishes to pursue
- Testing & incorporation of prioritized primary care infrastructure or performance metrics into OHA measurement and reporting
- Future presentations to and direction from Board members, for final recommendations in December





Oregon Primary Care Infrastructure Investment: Policy and Measurement Strategies

Prepared for:

Oregon Health Authority,
State Innovation Model Grantee

Prepared by:

Center for Health Care Strategies &
State Health Access Data Assistance Center

April 2014

Contents

Executive Summary	Error! Bookmark not defined.
Introduction	Error! Bookmark not defined.
Section 1. Levers to Boost Multi-Payer Primary Care Infrastructure Investment	Error! Bookmark not defined.
1.1 Legislation	Error! Bookmark not defined.
1.2 Formalizing a Multi-Payer PCPCH Collaborative.....	Error! Bookmark not defined.
1.3 Health Plan Regulation.....	Error! Bookmark not defined.
1.4 Engaging Self-Insured Employers	Error! Bookmark not defined.
Section 2. Primary Care Revenue Enhancement Strategies	Error! Bookmark not defined.
2.1 Increase the Percentage of Health Payments Spent on Primary Care.	Error! Bookmark not defined.
2.2 More Comprehensive Capitation Rate.....	Error! Bookmark not defined.
2.3 Higher Primary Care Rates	Error! Bookmark not defined.
2.4 Pay for Performance Incentives	Error! Bookmark not defined.
2.5 Shared Savings.....	Error! Bookmark not defined.
Section 3. Practice Transformation Supports	Error! Bookmark not defined.
3.1 Multi-Payer Financial Investment in Practice Transformation	Error! Bookmark not defined.
3.2 Practice Facilitation.....	Error! Bookmark not defined.
3.3 Primary Care Extension Program.....	Error! Bookmark not defined.
Section 4. Enhanced Primary Care Provider Workforce	Error! Bookmark not defined.
4.1 Commercial Insurer Contribution to Graduate Medical Education	Error! Bookmark not defined.
4.2 Expanded Scope of Practice Laws.....	Error! Bookmark not defined.
4.3 Retraining the Clinical Workforce.....	Error! Bookmark not defined.
Section 5. Measurement Strategies	Error! Bookmark not defined.
5.1 Monitoring the Impacts of Policies to Enhance Primary Care Infrastructure	Error! Bookmark not defined.
5.2 Supports for Primary Care Practice Transformation.....	Error! Bookmark not defined.
5.3 Monitoring Primary Care System Performance.....	Error! Bookmark not defined.
Conclusion	Error! Bookmark not defined.9

Executive Summary

This paper presents a range of options for advancing and measuring multi-payer investment in Oregon's primary care system, with an emphasis on promoting commercial payer investment in the state's patient-centered primary care home (PCPCH) program. Of the many levers and strategies included in the paper, the following deserve top consideration—due to their implementation feasibility, compatibility with Oregon's current policy environment, and success in other states:

- **Formalize the existing PCPCH Workgroup to increase the PCPCH program's size, scope and impact:** Oregon's Multi-Payer Primary Care Payment Strategy Workgroup includes a range of members from the payer and provider communities, but lacks the formal reporting processes, oversight mechanisms, and governance structure to efficiently and effectively promote its goal of mutually investing in and committing to “accountable, sustainable, patient-centered primary care that results in achievement of the triple aim.” To strengthen the Workgroup as a vehicle for multi-payer alignment and investment in primary care, Oregon can consider key success factors from other states:
 - *Developing a charter with a formal governance structure:* A charter with clearly defined goals, rules, and decision-making processes can enhance the Workgroup's ability to drive change.
 - *Establishing workgroups to focus on concrete goals.* Establishing Workgroup sub-committees with specific charges and regular meeting schedules can help the Workgroup address specific, high-priority issues. One sub-committee, for example, could focus on advancing alignment between the PCPCH program and existing efforts—most notably, the state's multi-payer Comprehensive Primary Care Initiative.
 - *Assessing the convener role:* States have used a range of different public and private conveners to lead multi-payer efforts. Oregon should consider whether organizations like Oregon Health & Science University's Evidence-based Practice Center or the Oregon Health Care Quality Corporation (Q Corp) are best-positioned to lead the Workgroup.
 - *Publicly reporting accomplishments:* Measuring and reporting payer-specific progress on achieving Workgroup goals can help hold payers accountable for reaching agreed upon milestones and goals.
 - *Obtaining visible support from a state leader:* Direct support from the governor or a high-ranking state representative can provide publicity and credibility.
- **Use PCPCH outcomes to develop a business case for engaging new payers:** The state should measure and analyze the PCPCH program's impact on costs, utilization, and health outcomes to quantify its overall value. A performance-oriented evaluation can help the state spread successful strategies and modify less successful program components. If the results suggest a favorable return-on-investment, the state can use this information to create a business case to attract new commercial and self-insured payers to the program. While self-insured employers are not easy to engage, producing results that demonstrate a medical home program's cost effectiveness and positive health impact are the most likely way to draw their interest.

- **Encourage more innovative payment strategies:** PCPCH payers have considerable flexibility in the types of innovative payment methods they employ. The state can encourage PCPCH payers to incorporate more outcomes-based payment strategies—such as shared savings methodologies—into their arrangements with providers (particularly if strategies align across payers or programs). Oregon can do this using one or more levers, including incorporating more specific payment requirements into a Workgroup charter (as noted above), setting specific goals or reporting requirements for payers, or mandating the use of new payment strategies via legislation.
- **Broaden PCPCI’s funding sources and scope:** The Patient Centered Primary Care Institute (PCPCI) is funded solely by the Oregon Health Authority. Oregon can explore ways to elicit direct commercial payer support for PCPCI, such as through legislation or a more formalized agreement with participating private insurers. Establishing a business case for the PCPCH program and the use of practice transformation supports can support this effort. With enhanced multi-payer funding, PCPCI can explore additional services to offer practices, such as establishing a network of extension agents to lead in-person practice facilitation activities and link providers to community resources.

Introduction

Rapid transformation in health care coverage and financing is taking place in Oregon, with extensive implications for the primary care system and primary care infrastructure. The Affordable Care Act is expected to reduce the number of people without insurance in Oregon from about 550,000 in 2013 to 170,000 in 2016.¹ Simultaneously there is a major shift in how health care is paid for and delivered – especially in the Oregon Health Plan (OHP) – but also through other purchasers including the state, public employee groups, and commercial health plans.

Investing in primary care is a central strategy for transforming the delivery and financing of care. Over 484 clinics have been certified as Patient-Centered Primary Care Homes (PCPCHs) since Oregon began its PCPCH program in 2009.² For the first three quarters of 2013, 78.1 percent of OHP beneficiaries enrolled in Coordinated Care Organizations (CCOs) were enrolled in a recognized PCPCH, up from 51.8 percent in 2012.³ Additionally, 67 practices are participating in the multi-payer Comprehensive Primary Care Initiative (CPCi). To support the transformation of overall health care delivery via a more robust primary care system, the state has invested in the Patient-Centered Primary Care Institute (PCPCI), which provides technical assistance to primary care practices that are seeking to become state-recognized PCPCHs. PCPCI is run by the Oregon Health Care Quality Corporation (Q Corp) and offers programs such as behavioral health integration training; learning collaboratives; and a learning network of technical assistance experts.

Research suggests greater investment in primary care can lead to lower total health care costs, better patient outcomes, and fewer population health disparities.^{4,5} More specifically, access to a regular primary care physician is associated with higher rates of preventive care and lower rates of preventable emergency department visits, hospital admissions, and specialist utilization.^{6,7,8} Many states are investing in wide-ranging primary care strategies that include participation from commercial insurers. Examples include:

- *Vermont*: The multi-payer Blueprint for Health establishes a new primary care-focused health services model for Vermont, centered on the creation of patient-centered medical homes (PCMHs) and multidisciplinary community health teams (CHTs), which support PCMHs and provide a range of health services. An integrated information technology infrastructure supports the primary care delivery system. Results from 2012 published by Vermont demonstrated that people who received primary care in the PCMH + CHT setting had lower total health expenditures versus a comparison group; lower rates of medical and surgical specialty care; higher rates of primary care; and higher rates of some preventive services. Commercial insurer and Medicaid investments were more than offset by reductions in health care expenditures.⁹
- *North Carolina*: Community Care of North Carolina (CCNC), a statewide network of primary care providers, established multi-payer medical homes for more than a million residents across the state. In collaboration with the North Carolina Area Health Education Center, CCNC provides physicians with resources to better manage enrolled populations; links providers to local health systems, hospitals and health departments; and trains a multidisciplinary health care workforce

- *Rhode Island*: Under the Chronic Care Sustainability Initiative (CSI), a multi-payer PCMH initiative, Medicaid and commercial payers use a common contract that specifies uniform practice requirements and performance metrics; payers also jointly fund nurse care managers. The state further invests in primary care through a set of affordability standards that require commercial insurers to invest an increasing percentage of their total spend on primary care services and non-fee-for-service payment models.

The purpose of this paper is to help Oregon identify potential next steps for its primary care investment strategy, with an emphasis on enhancing the engagement of commercial payers in primary care programs and aligning public and private payment and care delivery models. This paper begins by exploring the levers Oregon can use to advance primary care programs and policies; it then highlights the policy approaches other states have used to stimulate multi-payer investment in the primary care system. The paper concludes with a review of metrics that could be used to monitor the impacts of the primary care investment policies described in the paper and track primary care system performance. This paper aims to focus on policies and metrics pertaining to both commercial payers and state-run insurance programs; however, some of the strategies included are applicable only at the state level (such as those pertaining to workforce investments).

Section 1. Levers to Boost Multi-Payer Primary Care Infrastructure Investment

Primary care transformation becomes increasingly viable as more payers invest in infrastructure development and pay providers through non-fee-for-service arrangements. Building a coordinated strategy across multiple payers has the following benefits:

- Providing consistent messaging and incentives to primary care practices;
- Reducing the administrative burden associated with different payment methodologies and expectations;
- Avoiding the economic “free rider” problem of some entities benefiting from others’ investments; and
- More widely distributing costs and risks.

States can assume a variety of roles to promote multi-payer primary care investment: policymaker, payer, regulator, convener, and grantmaker. Oregon can consider the different roles that it can assume at different times—as well as the levers it can use to promote commercial insurers’ meaningful investment in the state’s primary care infrastructure. Four core strategies are highlighted below: (1) legislation; (2) formalizing a multi-payer collaborative; (3) health plan regulation; and (4) engaging self-insured employers. Oregon can consider applying any of these levers to implement the primary care investments described in more detail in Sections 2 and 3 of this paper.

1.1 Legislation

Passing legislation to boost primary care infrastructure investment can be a high-cost/high-reward lever. The legislative process can be slow and unpredictable, but if a policy is successfully enacted through legislation, it will likely have legitimacy and staying power. That being said, there is no guarantee that a legislatively mandated policy will be any more successful than a voluntary policy. A number of states—

including Maryland, New York, Minnesota, and Vermont—relied on legislation to secure multi-payer participation in state-based PCMH pilots. Legislation can also be used to require insurance companies to invest in primary care. Oregon could use legislation to require enhanced commercial participation in the PCPCH program or establish a new statewide entity focused specifically on creating and enforcing primary care payment and investment policies.

One limitation with using legislation to enact primary care policy changes is the fact that it does not hold sway over self-insured employers due to the ERISA preemption, which prohibits state laws from regulating ERISA plans (this also holds true for health plan regulation, discussed in section 1.3 below).

EXAMPLES OF LEGISLATION TO ESTABLISH MULTI-PAYER MEDICAL HOME PROGRAMS AND NEW STATE ENTITIES

Legislation establishing multi-payer medical home programs

- In 2010, the **Maryland** legislature passed SB855/HB929 requiring all payers with premium revenues of more than \$90 million to participate in the Multi-Payer Patient Centered Medical Home Program (MMPP). Legislation was used to compel participation and provide the antitrust protection Maryland payers needed to participate. Results to date:
 - In comparing results of MMPP with comparison sites between 2010 and 2011, MMPP was associated with substantial improvements ($p < 0.10$) in three of 13 quality measures (young adult hospital admissions due to asthma, adolescent well-care visits, and cervical cancer screenings), two of 12 utilization measures (office visits to an attributed primary care physician, office visits to specialty physicians), and four of 12 cost measures (total outpatient payments, primary care office visit payments, total other costs, and total laboratory payments).¹⁰
- Chapter 58 of the Laws of 2009 (the 2009-2010 state budget) created **New York's Adirondack Multi-Payer Demonstration**. Legislation provided antitrust protection for payers to collaborate and specified terms of the demonstration, though did not mandate payer participation. All seven of the region's commercial payers, Medicare, and Medicaid joined the demonstration, in part due to providers' strong advocacy efforts. Payer concerns included:
 - Issues around time, capacity and coordination, as some payers were already participating in other pilots;
 - Insufficient data on the model's return for payers; and
 - Finding a mutually acceptable PMPM payment level was difficult. (This issue was solved with the providers hired an outside accounting firm to estimate the PMPM cost of the demonstration's requirements. The estimate of \$8.40 PMPM was ultimately negotiated down to \$7 PMPM.)

*Legislation establishing new state entities**

- **Massachusetts'** Chapter 224, passed in 2012, created the **Health Policy Commission (HPC)**, an independent state agency charged with reducing overall health care cost growth; improving access to quality, accountable care; and reforming the way health care is delivered and paid for. HPC is funded through the state's Healthcare Payment Reform Fund until June 30, 2016; after that date, HPC will be funded through assessments on hospitals, ambulatory surgical centers, and surcharge payers. Its activities include:
 - Establishing an annual cost growth benchmark and monitoring whether spending has exceeded the target; the benchmark for 2013 is 3.6 percent;
 - Conducting cost trends hearings and publishing a cost trends report (the only explicit primary care measure included in the 2013 report is "ED visits that are preventable or avoidable with timely and effective primary care");
 - Analyzing the performance of provider organizations with revenues of \$25 million or more and requiring provider groups with above-target spending to submit plans for corrective action;
 - Reviewing provider changes, including consolidations and alignments; and

- Developing and implementing standards for Massachusetts PCMHs.
- The **Rhode Island** Health Care Reform Act of 2004 (Chapter 42-14.5) established the nation's first Office of the **Health Insurance Commissioner**, separating health insurance regulation from the Department of Business Regulation. The decision to pursue this legislation came from the realization that the state did not have the information or authority needed to affect the relationship between insurers and providers in the large- and small-group insurance markets. The legislation added two new standards to the traditional roles of a health insurance regulator: (1) to hold health insurers accountable for fair treatment of providers; and (2) to direct insurers to promote improved accessibility, quality, and affordability.

** These examples are not specific to primary care, but describe entities Oregon could use as models to promote primary care investment*

1.2 Formalizing a Multi-Payer PCPCH Collaborative

Another possible strategy to improve primary care infrastructure investment is to leverage the existing Multi-Payer Primary Care Payment Strategy Workgroup (the “Workgroup”), convened and facilitated by Oregon Health & Science University’s Evidence-based Practice Center, to create and implement ongoing primary care investment goals. This group, which includes the state’s major commercial insurers, Medicaid CCOs, primary care provider organizations, and the state, produced strategic recommendations for public and private payers to support primary care homes. Workgroup members signed an agreement in November 2013 to offer structured payments to support patient-centered primary care homes, using Oregon’s PCPCH recognition standards.

Oregon has an opportunity to build on the momentum and decisions established by the Workgroup to drive progress in multi-payer participation and alignment around the PCPCH program. Oregon should consider formalizing this entity to ensure its ongoing sustainability. In formalizing the Workgroup, the state should consider the following questions:

- *Purpose/Scope:* What should the Workgroup focus on and what is its ultimate objective? Should it only work on PCPCH participation and payment issues or should it expand its scope to additional issues related to multi-payer primary care infrastructure? How might the Workgroup include existing multi-payer PCMH efforts such as the Comprehensive Primary Care Initiative?
- *Authority:* Should the Workgroup have any decision-making or enforcement authority regarding new policies?
- *Governance and oversight structure:* Should the Workgroup be governed by a formal charter or memorandum of understanding? How should the Workgroup be structured to facilitate consensus building and informed decision-making?
- *Members:* What stakeholders should be invited to participate in the group? Is the group open to new members?
- *Convener:* Is the Evidence-Based Practice Center the right convener for the Workgroup, or should another entity (such as the state or Q-Corp) assume control? Neutrality, the ability to develop consensus, and trust among commercial payers will be critical for a successful convener.
- *Meeting requirements:* What type of meeting schedule would facilitate progress while not being too burdensome? How will the meetings be structured?

- *Reporting requirements:* Should the Workgroup be required to submit reports or updates, and if so, for what audience?

EXAMPLES OF MULTI-PAYER COLLABORATIVE COMMITTEE AND GOVERNANCE STRUCTURES

State-based

- The **Idaho** Medical Home Collaborative (IMHC) includes four large payers, state officials, physician groups, and patient and employer representatives. Each member signed a charter to agree to participate, which included five main sections:¹¹
 - *Purpose:* Describes the purpose of IMHC as making “recommendations on the development, promotion and implementation of a Patient-Centered Medical Home model of care statewide.”
 - *Authority/Reporting:* Asserts that members shall be assigned by the Governor and overseen by the Department of Insurance.
 - *Membership:* Lists all current members.
 - *Member Responsibilities:* Contends that members are to attend all meetings, actively participate and commit to follow-through on assignments.
 - *Meetings and Structure:* Notes that the group will meet on a monthly basis.
- **Montana’s** Commissioner of Securities and Insurance was charged with planning and convening a multi-payer medical home effort in 2010. In 2013, the commissioner published a set of rules relating to the PCMH program, including rules around the establishment and duties of the Patient-Centered Medical Homes Stakeholder Council. The following rules were included:¹²
 - The stakeholder council consists of 15 members appointed by the Commissioner to serve 12-month terms.
 - The Commissioner shall consult with the Stakeholder Council before proposing new PCMH rules.
 - The Council shall advise the Commissioner regarding PCMH activities.
 - The Council shall meet at least twice a year (since November 2013, the Council has met every month).
- **Rhode Island’s** multi-payer CSI is convened by the Rhode Island Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services. CSI has the following governance structure:
 - *Steering Committee:* Responsible for the strategic direction and overall governance of the project.
 - *Executive Committee:* Makes recommendations to the Steering Committee regarding the strategic direction and overall governance of the project, including two subcommittees:
 - *Marketing and Communications Subcommittee:* Increases awareness and demand for PCMH. Target audiences include: employers and labor unions.
 - *Patient Advisory Subcommittee:* Serves as the voice of the patient and family.
 - *Working Committees:* Includes subcommittees on Practice Training Support and Transformation, Practice Reporting, Data and Evaluation, Payment Reform and Contracts, and Service Expansion.
 - Current governance considerations include: developing by-laws to address electing co-chairs, committee membership, and term limits; monitoring project as it grows for risk of scalability; and assessing and identifying ways to formalize CSI structure as an entity.
- In 2013, insurers and providers in **Nebraska** signed a Participation Agreement to recognize and reform payment structures to support Patient Centered Medical Homes. The agreement includes the following information:¹³
 - *Effective dates:* January 2014 – January 2016.
 - *Goals:* Insurers will have active PCMH contracts with approximately 10 clinics by the end of 2014 and approximately 20 clinics by the end of 2015.
 - *Definitions:* Provides a definition of a PCMH in Nebraska.
 - *Payment:* Insurers offering a medical home program must utilize payment mechanisms that recognize value beyond the fee-for-service payment. The design and details of the payment mechanism will be left up to each individual health plan.
 - *Progress Reports:* Participating payers are asked to report annually, by letter, successes realized and

challenges faced in their efforts to comply with this agreement. The report should include the number of PCMH contracts signed.

- **Colorado's** multi-payer PCMH pilot—which included five private and two public health plans—was convened by HealthTeamWorks, a nonprofit, multi-stakeholder collaborative. While each health plan developed its own contract with practices, HealthTeamWorks reduced fragmentation between plans by writing suggested contract language. Plans used this language as a starting place and then adapted it to best meet their needs.

Independent

- **California's Integrated Healthcare Association**, a multi-stakeholder nonprofit group, serves as the neutral administrator of the California Pay for Performance Program, the largest non-governmental physician incentive program in the United States. IHA board members include health plans, physician groups, and hospital systems, as well as academic, consumer, purchaser, pharmaceutical, and technology representatives. IHA began its pay for performance program with a statement of vision, goals, core principles and project objectives. It also established ground rules that defined the scope and operation of the program. IHA has a set of core committees, each with nine voting members:¹⁴
 - *Technical Efficiency Committee*: Develops cost-efficiency and resource use measures;
 - *Technical Quality Committee*: Develops quality measures;
 - *Steering Committee*: Reviews Technical Committees' recommendations and responsible for making final decisions and overseeing the program;
 - *Executive Committee*: Handles long-term planning and provide more frequent direction to program staff; and
 - *Payment Committee*: Explores and recommends common incentive payment methodologies.

1.3 Health Plan Regulation

Oregon can influence commercial insurers' investment in primary care through the rate review process and/or its authority over the certification of Cover Oregon carriers and regulation of qualified health plans (QHPs).

Rate Review and Financial Reporting

Oregon can use the rate review process—or an alternative financial reporting process—to monitor commercial health plans' primary care investment patterns and mandate enhanced payer contributions to primary care services (see Table 1 in section 5.1 for specific measures to use in assessing changes in payment policies). Oregon could use the rate review or financial reporting process to:

- *Gather information on primary care spending*: Oregon could use rate review to require commercial insurers to disclose information about: (1) annual spending on primary care services; (2) incentives to increase primary care activities (both the direct provisions of services and investment in transformation activities and infrastructure supports); (3) any assumptions about primary care usage and cost that are included in premium calculations; (4) and hospital and provider pricing, contract terms, and spending trends.
- *Set standards or goals at the insurer level*: The state could encourage or require insurance companies to incorporate best practices in contracts with providers and then report on the results. Potential standards include:
 - Increasing the percentage of total spend on primary care;
 - Engaging in primary care-based quality improvement efforts;
 - Adopting the PCPCH care model and/or investing in PCPCH practices;

- Tying outcomes to payment and reimbursement; and
- Requiring public and standardized provider contract terms.
- *Use investment in primary care as a factor in approving/denying rate increases:* Oregon could adjust rate review methodology to account for the total percentage of spend insurers invest in primary care (with insurers who invest more in primary care being “rewarded” with slightly higher rate increases).

EXAMPLES OF LEVERAGING THE RATE REVIEW PROCESS

- In 2007 the **Rhode Island** Insurance Commissioner’s office updated its rate review process to make rate filings annual, consistent across lines of business and insurers, and transparent. The next year the state began to require insurers to report how they were addressing affordability with their rate filings—yet these descriptions tended to be nonspecific lists of activities around disease management, wellness programs, and benefit design. To obtain more specific information and set clearer expectations for insurers, the insurance commissioner then developed four formal affordability standards, using the annual rate review process “as the point of leverage” (See section 2.1 for more information about Rhode Island’s affordability standards).
- **New York** is exploring how to use the rate review process to gather information from insurers on their investments in value-based payment models and value-based insurance design. Insurers would be asked to describe the penetration over time of value-based payments models within their provider portfolios, as well as the implementation of Advanced Primary Care models by recognition level.

Authority over Exchange Plans

Oregon could also use its authority over the Cover Oregon health exchange to promote primary care goals in exchange-based qualified health plans (QHPs). Cover Oregon is authorized to act as an active purchaser when contracting with plans, and can set requirements for QHPs that are stronger than the outside market in several areas. The state could:

- *Establish primary care standards for QHPs or exchange carriers:* The state can consider setting specific primary care standards for participation on the exchange, related to plans’ benefits package or carriers’ primary care spending or investment in primary care transformation.
- *Steer consumers toward “high value” plans:* Oregon can work to steer consumer toward plans that invest more in primary care by establishing a favorable rating or designation system for plans that meet certain primary care criteria, or by displaying these plans more prominently on the Cover Oregon website.

1.4 Engaging Self-Insured Employers

Self-insured employers, not subject to state payment and delivery system reform policies due to the ERISA exemption, can be challenging to engage in primary care transformation efforts. As states cannot mandate program participation or adherence to state policies, their only option to secure employer participation may be to educate and engage employers about why investment benefits them—and why it is important to have consistent policies across employers, commercial insurers, and public payers.

To engage employers in adopting the PCPCH model or other state-based models, Oregon could:

- *Make the business case for PCPCH:* Employers want to know about the anticipated return-on-investment for any new investment. While Oregon has access to a wealth of information about generic medical home program results, the most convincing data it can present employers will be data directly from the PCPCH program itself. The state must rigorously measure PCPCH progress and outcomes, using key data points to compute the program’s return-on-investment and craft a business case for why employers should join the effort.
- *Identify a key employer champion:* Some companies have publicly supported the medical home model; IBM, for example, is currently participating in six multi-payer pilot projects in New York and Vermont. In Cincinnati, the key to getting more employers and payers to participate in delivery system reforms was having GE lead the cause. GE took charge of calling meetings to discuss new payment strategies and set up an Executive Stakeholder Council; other employers, health plans, and provider groups then joined the effort. If Oregon can find one champion like IBM or GE—a large company that is willing to be out in front—other employers may be more likely to follow suit.

EXAMPLES OF ENGAGING SELF-INSURED EMPLOYERS

- **Maryland** created a Frequently Asked Questions document for self-funded employers around participating in the state’s multi-payer PCMH pilot.¹⁵ The state also created a list of “Incentives for Self-Insured Employers who Participate in the Program” on its website.¹⁶ Self-insured employers voluntarily choosing to participate in the pilot include Maryland hospital systems.
- **Minnesota** state government staff are working with employers to provide education and develop strategies to encourage the integration of Health Care Home payments into insurance products. The state estimates that 15 percent of the self-insured market will voluntarily participate by the end of the demonstration period.

Section 2. Primary Care Revenue Enhancement Strategies

Nationwide, the percentage of total health care expenditures devoted to primary care is between five and six percent.¹⁷ Some experts have advocated for payers to increase this share to 10 to 12 percent of expenditures, based on the hypothesis that greater investment in primary care could reduce long-term costs and improve the quality of care if invested in more efficient and evidence-based processes.¹⁸

Below are strategies that would increase the amount or percentage of health care funding invested in primary care services.

2.1 Increase the Percentage of Health Payments Spent on Primary Care

With the necessary statutory authority, Oregon could deploy the one or more of the levers discussed in Section 1 to require or encourage health plans to gradually increase the proportion of total payments made to primary care services. The state would first need to determine a current baseline for each major carrier and then propose reasonable future standards.

EXAMPLE OF INCREASING THE PROPORTION OF PAYMENTS MADE TO PRIMARY CARE SERVICES

- Beginning in 2010, **Rhode Island's** OHIC began requiring the state's main commercial insurance companies to increase the share of total medical payments made to primary care by one percentage point per year from 2010 to 2014. This spending cannot result in higher premiums and cannot increase overall medical expenses; rather, it must reflect a shift in issuers' primary care payment strategies away from the dominant FFS system. Results:
 - In 2012, insurers spent 9.1 cents of every fully insured commercial medical dollar on primary care services, an increase of nearly 3.5 cents from 2008. Insurers also continue to invest in non-FFS methods, particularly PCMHs, to drive their primary care spending. From 2008 to 2012, spending on primary care in Rhode Island grew 37 percent, and in 2012, the market spent \$7 million more on primary care than it did in 2011. While overall medical spending declined during this time period, the state does not attribute this change to higher primary care spending, but rather to a variety of other factors—such as the recession, benefit changes, and a shift to self-insurance. Since the Affordability Standards went into place, insurers have met their primary care spending requirements and have greatly increased investments in non-FFS projects, with 34 percent of all primary care costs attributed to non-FFS spending.¹⁹

2.2 More Comprehensive Capitation Rate

Payers participating in the PCPCH program can consider offering practices an all-inclusive per member per month (PMPM) payment for clinical services and other medical home activities. A more comprehensive capitation rate could cover all practice expenses, essential infrastructures and systems, and salaries,²⁰ or more minimally, cover behavioral health services, care coordination, and case management, similar to the Massachusetts model highlighted below.

EXAMPLE OF A MORE COMPREHENSIVE CAPITATION RATE

- As part of **Massachusetts' Primary Care Payment Reform Initiative**, MassHealth (Medicaid) will pay participating practices a Comprehensive Primary Care Payment (CPCP), a risk-adjusted per member per month payment for a defined set of primary care and behavioral health services: to include evaluation and management, case management, care coordination, and behavioral health coordination. MassHealth plans to base the CPCP on Medicare rates, at least until December 31st, 2014.

2.3 Higher Primary Care Rates

Increasing Rates Based on Medical Home Recognition

Many examples exist for how commercial and public insurers can reward primary care practices for increasing their levels of “medical home-ness,” though these examples may increase existing FFS or PMPM payments, rather than promoting innovative payment methodologies.

EXAMPLES OF HIGHER PAYMENT RATES BASED ON MEDICAL HOME RECOGNITION

Multi-payer

- Under the **New York Statewide Patient-Centered Medical Home Program**, National Committee for Quality Assurance (NCQA)-recognized hospital outpatient clinics and office-based practitioners are eligible to receive enhanced service

rates for certain evaluation and management and preventative medicine codes for participating enrollees. The payments vary by NCQA recognition level. **Oklahoma, Nebraska** and **Maryland** also tier medical home payments, with practices that achieve higher levels of recognition rewarded with higher PMPM payments.

Medicaid

- **Colorado** increased evaluation and management codes for primary care visits to 90 percent of the Medicare rates. Practices receive a significantly higher bump for Medicaid preventive visits (120 to 130 percent of the Medicare rate) if they complete a medical home index questionnaire and meet medical home standards developed by the state.

Commercial

- **Blue Cross and Blue Shield of North Carolina** (BCBSNC) pays an enhanced fee-for-service amount for evaluation and management codes billed to BCBSNC practices that apply for NCQA PCMH recognition.

Increasing Rates for all Primary Care Providers

Oregon can consider extending the Affordable Care Act's Medicaid primary care rate increase past 2014 or otherwise work to align Medicaid primary care reimbursement levels with Medicare and commercial levels. It could also support legislation to extend equal pay for primary care nurse practitioners and physician assistants outside independent practices (HB 2902, passed in 2013, guarantees pay parity for NPs and PAs in independent practices). Commercial insurers in the state could also choose to raise reimbursement rates to all primary care providers.

EXAMPLES OF HIGHER PAYMENT RATES FOR ALL PRIMARY CARE PROVIDERS

Medicaid

- Both **Colorado** and **Maryland** have proposed maintaining the ACA primary care rate increase past 2014. Colorado's governor has included the rate bump in his proposed 2015 state budget.

Commercial

- In early 2012, **WellPoint** announced plans to spend \$1 billion or more to increase primary care doctors' fees by roughly 10 percent within its network of 100,000 primary care providers. The insurer estimates the new payment approach could result in a 20 percent reduction in projected medical costs by 2015.

2.4 Pay for Performance Incentives

The state can consider establishing a multi-payer pay for performance (P4P) program at the practice or individual provider level, rewarding providers directly for meeting primary care targets, including successful primary care transformation. The state could couple a P4P program with its PCPCH program to establish a greater connection between PCPCH investments and quality outcomes and create a stronger business case for commercial plans. Payers can offer extra payments as a reward for certain processes (establishing EHRs and registries, after-hours care, meeting medical home standards) or outcomes (reducing ED visits, hospitalizations, total cost of care, etc.).

EXAMPLES OF PAY FOR PERFORMANCE INCENTIVES

Multi-payer

- In **Rhode Island's** multi-payer CSI, the PMPM payment increases or decreases based on achievement of performance targets related to utilization, quality and member satisfaction, and process improvement. Practices receive: \$5.00 PMPM if 0-1 of the three performance targets is achieved; \$5.50 if the utilization target and one other performance target are achieved; or \$6.00 if all three performance targets are achieved.
 - After two years, CSI was associated with substantial improvements in medical home recognition scores and a significant reduction in ambulatory care sensitive emergency department visits. Although not achieving significance, there were downward trends in emergency department visits and inpatient admissions.²¹

Medicaid

- In **Colorado's** Accountable Care Collaborative, a \$20 PMPM is divided among three entities: PCPs, Regional Care Collaborative Organizations (RCCO), and a Statewide Data and Analytics Contractor. \$1 PMPM is withheld from both the PCP and the RCCO, creating a shared quarterly incentive payment pool. The \$1 PMPM can be recouped by each entity by meeting key performance indicators, including: reduced ED utilization, reduced hospital readmissions, reduced utilization of medical imaging, and well-child visits.
- **Connecticut** Medicaid's Husky Health PCMH program provides incentive payments for practices in the top tenth percent for performance (fractions of the incentive payment begin phasing in at the 25th percentile) and improvement payments (practices in the top 10 percent for improvement will receive 100 percent of the possible improvement payment).
- **Oklahoma's** SoonerExcel program (Medicaid) makes quarterly payments to PCPs who meet or exceed expectations in: inpatient admitting and visits, breast and cervical cancer screenings, ED utilization and EPSDT and immunization targets.

2.5 Shared Savings

Payers can implement a shared savings component within the PCPCH model, with accrued savings awarded based on primary care performance and reinvested in primary care infrastructure and staff. This approach aligns with the shared savings component that will be implemented as part of the multi-payer Comprehensive Primary Care Initiative, in which 67 Oregon practices participate:

- *Award savings based on providers' performance on primary care indicators:* The shared savings program can be structured to reward primary care practices that meet pre-determined primary care quality goals and/or save money by reducing acute care utilization.
- *Require practices to invest shared savings in primary care infrastructure or PCP incentives:* In addition to suggesting *who* is awarded savings accrued in a shared savings payment design, the state could consider being more prescriptive about *how* these savings are re-invested at the practice level. Requiring providers to reinvest all or a portion of accrued savings in primary care infrastructure (such as upgraded or enhanced health information system technology and additional care coordinators and support staff) could help practices quickly develop into higher-functioning primary care homes.

EXAMPLES OF SHARED SAVINGS PROGRAMS

Multi-payer

- **Maryland's** Multi-payer PCMH Program includes a shared savings payment in which primary care practices can earn a percentage of the savings they generate through improved care and better patient outcomes. Practices that meet performance and measurement criteria and achieve savings relative to their own baseline will receive a percentage of cost savings. These shared savings calculations comprise all patient costs, including approximately 94 percent of costs that occur outside the primary care practice (e.g. in hospitals, specialist physicians, laboratories, etc.). The first of these payments was made in the fall of 2012, and payments were based on performance during 2010 and 2011; 23 of 52 participating practices received shared savings payments from private insurers. Total incentive payments, based on 2011 performance metrics and savings, were \$815,670.²²
- **Northeastern Pennsylvania's** Chronic Care Initiative has a shared savings program that pays providers "value reimbursement payments" if: (1) they have met a certain number of performance criteria; and (2) the savings generated exceed the annual value of the other ongoing medical home payments.

Commercial

- **California's** Integrated Healthcare Association (IHA) added a shared savings provision to its P4P program to reward practices for performance on a series of resource use measures (including inpatient utilization and emergency department visits). IHA calculates risk-adjusted rates using data from all of the IHA participating health plans, and the health plans calculate savings using their own unit cost data. Savings are shared based on a formula that allocates savings between the provider organization, the health plan, and employers (in the form of future premium trend reduction).
- In 2009, BCBS of **Massachusetts** instituted global budgets coupled with financial risk and performance bonuses with seven provider organizations under its Alternative Quality Contract (AQC). Sixteen provider organizations (most with a mix of primary care providers and specialists) are now participating in the contract. The AQC rewards provider groups with up to 10 percent of their global budget for meeting 64 quality measures. Researchers found that AQC providers reduced the rate of increase in health spending by 3.3 percent in the second year, up from 1.9 percent in the first year. Quality of care also improved compared to control organizations, with chronic care management, adult preventive care, and pediatric care within the contracting groups improving more in year two than in year one.²³

Medicaid

- **Massachusetts** Medicaid's Primary Care Payment Reform, implemented in 2013, includes a shared savings payment (in addition to a risk-adjusted capitation payment and quality incentives). Providers share in savings on non-primary care spending, including hospital and specialist services. There are also options for shared risk terms.
- **Arkansas'** Medicaid Patient Centered Medical Home program includes shared savings incentives for providers. Practices are eligible for shared savings if the practice: (1) completes all scheduled practice support activities through the ConnectCare Primary Care Case Management Program and meets a majority of practice support metrics; and (2) meets 2/3 or more of quality metrics.

Section 3. Practice Transformation Supports

Another strategy to boost Oregon's primary care infrastructure is for both public and private payers to provide financial and/or non-financial supports to assist primary care practices as they work to transform into primary care homes. Investment in practice transformation supports can address the barriers to PCPCH implementation highlighted in recent findings from PCPCH surveys and site visits: cost and lack of resources; staffing and training; time; and administrative burdens.²⁴

The state could develop PCPCH payer requirements in which all participating plans contribute a portion of costs to fund transformation services—or, alternatively, to directly fund Q Corp’s PCPCI (now solely funded by the state), which is providing technical assistance to PCPCH practice sites, including via in-person trainings and webinars. The strategies listed below could be deployed within PCPCI, which would complement existing state investments and practice engagement in practice transformation.

3.1 Multi-Payer Financial Investment in Practice Transformation

The state can work to enhance and complement the existing PCPCI efforts by providing new or more robust supports to practices and encouraging multi-payer investment in PCPCI. The examples highlighted below describe how public and private payers have jointly contributed to transformation or infrastructure supports within multi-payer medical home programs; similar payment schemes could be used in Oregon to require commercial plans to invest in PCPCI.

EXAMPLES OF MULTI-PAYER INVESTMENT IN PRACTICE TRANSFORMATION

Multi-payer

- In **Massachusetts’** multi-payer Patient-Centered Medical Home Initiative, participating commercial, state employee and public programs provide practices with start-up payments that range up to \$15,000 in the first year and \$3,500 in the second year.
- All payers in the **Michigan** Primary Care Transformation (MiPCT) Project contribute \$1.50 PMPM for practice transformation.
- In the Southeast **Pennsylvania** PCMH, each payer pays its share of the \$21,000 payment in proportion to the share of the practice’s revenue that comes from the payer.
- Practices in **Washington** State's multi-payer Patient Centered Medical Home Pilot received \$6400 stipends to attend 8 days of learning sessions.
- In **Rhode Island’s** Chronic Care Sustainability Initiative, Medicaid health plans partner with commercial payers to cover the salary and benefits of an on-site nurse care manager for each practice in the pilot program. The nurse care managers work on-site as an employee of each practice and see patients of all insurers.

3.2 Practice Facilitation

Oregon can explore incorporating an enhanced practice facilitation program into PCPCI’s services to help practices meet primary care home recognition standards and maintain improvements. Research on practice facilitation is mixed but generally positive: primary care practices are more likely to adopt evidence-based guidelines using practice facilitation, as compared with control practices.²⁵

EXAMPLES OF PRACTICE FACILITATION PROGRAMS

- **Oklahoma’s** SoonerCare Health Management Program used a contractor to employ, train, and deploy eight nurses to serve as practice facilitators statewide. The practice facilitators supported practice transformation by engaging in: team development; workflow redesign; creation of a registry, resource library, and educational materials; and quality improvement projects. An independent evaluation of 62 Health Management Program practices conducted between 2008 and 2009 found \$2.8 million in aggregate savings and a 16.5 percent improvement of on disease management quality measures.²⁶

- The **Oklahoma** Physicians Resource/Research Network (OKPRN), developed and tested a quality improvement method that includes performance feedback with benchmarking, academic detailing, practice facilitation, HIT support, and learning collaboratives. Four full-time practice enhancement assistants provide practices with audits and feedback, staff training, “cross-fertilization” of ideas, coordination of quality improvement initiatives, and facilitation of practice-based research network projects. Its activities have produced improvements in preventive services and diabetes care by sharing approaches to common challenges.²⁷
- **North Carolina**’s AHEC Practice Support Program employs 49 facilitators to work in teams based in each of the state’s nine regional AHEC centers. Each center has three to nine individuals with skills in quality improvement, EHR implementation, and EHR optimization. Each team works with 25-30 practices at a time and serves 1,100 practices statewide (generally 12 – 18 months at a time, onsite).
- The **Vermont** Equip Program, begun in 2008, uses Practice Facilitators (PF) to assist practices in becoming PCMHs and implementing and using HIT supports. PFs also work to build quality improvement capacity and help practices achieve other self-identified goals. The program’s 13 practice facilitators make twice monthly visits to practices, with one PF to every 8-10 practices.

3.3 Primary Care Extension Program

While PCPCI offers periodic Technical Assistance Expert Learning Network sessions to assist practices in transformation activities, it does not incorporate a large-scale, practice-based training program that sends experts, such as practice coaches or quality improvement professionals, directly into primary care practices. Oregon may wish to incorporate components of other states’ primary care extension programs—which deploy community-based agents or coaches to support practices as they transform into medical homes—in a multi-payer technical assistance plan.

EXAMPLES OF PRIMARY CARE EXTENSION PROGRAMS

- The **New Mexico** Health Extension Regional Offices (HEROs) were developed to improve community health and are located in underserved rural counties. Ten Regional HERO Officers support HERO agents, who link providers and communities to resources and offer provider education, research, and services like case management, practice support, and community health assessments. HERO agents help train community health workers, who provide case management services for patients with high urgent or emergent care utilization.
- The Public Health Institute of **Oklahoma** (PHIO) acts as the state hub for Oklahoma’s extension system. PHIO directs a certification process for county health improvement organizations, which contract with the four regional Area Health Education Centers (AHECs) to provide quality improvement support for primary care practices. Each AHEC has around 18 practice facilitators who perform practice audits, conduct patient surveys, train staff, and coordinate quality improvement initiatives.
- In 1998, **North Carolina**’s Medicaid program began Community Care of North Carolina (CCNC), which consists of 14 provider networks. These networks include the state’s nine regional Area Health Education Centers (AHECs), which employ Quality Improvement Consultants to support practices in process improvements. CCNC Networks return a portion of their PMPM for each enrollee to support the central AHEC office. Studies on CCNC suggest it has improved quality of care and yielded Medicaid a return of \$2 in savings for every \$1 invested.²⁸
- The **Pennsylvania** Spreading Primary Care Enhanced Delivery Infrastructure (PA SPREAD) is a public-private partnership that is working to coordinate the development of a statewide Primary Care Extension Service with a variety of partners. PA SPREAD and many of its partners (including PA AHEC Regional offices) offer practice facilitators to assist practices in transforming into medical homes. PA SPREAD has also formed a Practice Facilitator Forum to bring together facilitators from across the state to learn from and support one another.

Section 4. Enhanced Primary Care Provider Workforce

More robust primary care services cannot be delivered without an adequate primary care workforce, which includes physicians, nurse practitioners, physician assistants, nurses, care coordinators, case managers, and traditional health workers. Oregon is currently examining a variety of ways to boost the state's primary care workforce; below are three specific strategies to consider.

4.1 Commercial Insurer Contribution to Graduate Medical Education

Commercial payers almost never contribute directly to graduate medical education (GME) programs that train resident physicians, though they do contribute indirectly, as they pay relatively higher rates to teaching hospitals that sponsor residency programs. One estimate puts the “extra” amount paid by private insurers to teaching hospitals at \$7.2 billion in 2006 (with public funding for GME around \$15 billion).²⁹

Private payers are unlikely to contribute to GME unless they are mandated to do so or believe they have a strong incentive to contribute. Since 1997, the American College of Physicians has advocated for an all-payer GME system.³⁰ Under this system, a GME trust fund would be established that would pool payments from Medicare, Medicaid and private insurers (via an assessment on health insurance premiums). Oregon could consider drafting legislation that would require insurers to contribute a certain per member amount or percentage to GME, though this policy option has not led to much success in other states.

EXAMPLES OF COMMERCIAL INSURER CONTRIBUTIONS TO GRADUATE MEDICAL EDUCATION

- In **Idaho** and **North Carolina**, foundations associated with insurers contributed small funding amounts to GME. In Idaho, a foundation contributed \$400,000 for four years to fund rural GME training; in North Carolina, a foundation partnered with other state-based philanthropies to support two new family medicine residency slots over three years at a Federally Qualified Health Center. In both examples, the foundation funding supported start-up costs and was not sustainable over the long-term.
- **Kaiser Foundation Health Plan**, the insurance arm of Kaiser's integrated health delivery system, contributes a percentage of revenue to a community benefit pool that partially funds GME. Kaiser's insurance plan has a direct interest in funding residency slots, as doing so helps ensure that Kaiser has access to a steady supply of newly trained physicians. Data suggest about 50 percent of Kaiser Permanente GME graduates remain in the Kaiser system.
- Under **Maryland's** all-payer system, state-based hospitals do not receive direct GME payments from Medicare or Medicaid; GME payments are instead built into hospital rates. As a result, public and private payers contribute equally to GME.
- In 2013, the **California** legislature proposed a bill (HB 1176) that would require health insurers to pay \$5 per covered life to support GME in the state. The bill would also create a Graduate Medical Education Council, which would serve as a GME governance board, distributing funding to new and existing residency programs. The legislation did not pass.

4.2 Expanded Scope of Practice Laws

Oregon has relatively inclusive scope of practice laws for nurse practitioners and physician assistants, though is one of only 10 states that does not allow physician assistants to dispense medications.³¹ Oregon could work to change current law to allow physician assistants to prescribe and dispense medications and consider some of the recent changes Massachusetts made to its scope of practice laws. The state could also consider laws that would encourage primary care practices to hire more non-

physician staff, such as enabling ancillary staff to assume greater responsibility for patient care. A recent *Annals of Family Medicine* article found that many primary care practices have a relatively limited staff structure: among a group of about 500 primary care practices participating in the Comprehensive Primary Care initiative, 53 percent reported having nurse practitioners or physician assistants; 47 percent, licensed practical or vocational nurses; 36 percent, registered nurses; and 24 percent, care managers/coordinators.³²

EXAMPLES OF EXPANDED SCOPE OF PRACTICE LAWS

- **Massachusetts'** recent cost containment legislation (Chapter 224) included a number of changes to professional scope of practice laws for physician assistants and nurse practitioners. The law changes the definition of the term "PCP" in existing Massachusetts law from "primary care physician" to "primary care provider." It also removes the limit on the maximum number of PAs that can be supervised by a single physician and the requirement that a physician must sign off on PA prescriptions. It requires health plans to include participating PAs in their searchable list of PCPs and to allow consumers to choose a PA as their PCP. Chapter 224 also promotes the use of limited-service clinics, which provide the option of obtaining non-urgent medical care without an appointment for a limited set of services within the scope of practice of a nurse practitioner.
- **Connecticut** established a non-partisan review committee in July 2011 at the Department of Public Health to review and submit recommendations to the legislature regarding all scope-of-practice issues. Changes to providers' scopes of practice must be submitted to the Department of Public Health no later than August 15 of the year preceding the legislative session during which the legislature is to consider the changes, and the department must provide feedback on the proposed changes to the legislature by February of the following year. Five scope-of-practice changes were reviewed under the new process for the 2012 legislative session and one, eliminating a face-to-face supervision requirement for physician assistants, became law.

4.3 Retraining the Clinical Workforce

Oregon can establish a grant program to support the efforts of medical facilities, trade associations and/or educational institutions to re-train workers in the skills needed to support team-based, patient-centered primary care. The state could also partner with payers, provider groups and other organizations to establish specific training programs for existing medical personnel, such as programs to train nurses in care coordination.

EXAMPLES OF CLINICAL RETRAINING PROGRAMS

- **New York's** Health Workforce Retraining Initiative, funded jointly by the New York State Department of Health and Department of Labor, supports the training and retraining of health and public health industry workers to acquire the skills needed to meet new job or certification/licensing requirements; support new models of integrated care management and interdisciplinary team based care; integrate health literacy into practice; and more. Since its inception, the program has awarded nearly \$352 million to 500 grantees and trained or retrained over 170,000 health care workers. The state's 2014-2015 program will provide over \$26 million in grants.³³
- **New Jersey's** Horizon Healthcare Innovations created a specialized nurse training program for nurses working in its parent Horizon Blue Cross Blue Shield of New Jersey's patient-centered medical home programs. Horizon invested more than \$1 million to fund the training program and provide payments to medical practices to hire care coordinators. In collaboration with Duke University School of Nursing and Rutgers College of Nursing, Horizon developed the 12-week course to train nurses to become population care coordinators, who act as patient coaches and advocates working to improve preventive and wellness care. Almost 40 nurses underwent training when the

program began in 2012, and Horizon hoped to train 200 nurses over the course of two years.³⁴

- The **Massachusetts** Hospital Association plans to provide a 10-week training program for nurses and social workers who wish to become care coordinators in accountable care organizations. The program is a combination of in-person and online learning. The training program is being co-provided by the Villanova University College of Nursing and The Geneia Institute, a program of Geneia, a healthcare innovations company.

Section 5. Measurement Strategies

Policymakers in Oregon are interested in monitoring the primary care system and primary care infrastructure in order to understand the impacts of ongoing changes in health care coverage and financing, and what policy responses may be needed to ensure adequate access to high-quality primary care for all Oregonians. This section provides suggestions on metrics that can be used to monitor the impacts of specific policies to enhance primary care infrastructure, and performance of the primary care system more generally.

Wherever possible, the suggested metrics are aligned with metrics that are being used for other purposes in Oregon, such as the quarterly Oregon Health Policy Board Dashboard, the Health System Transformation Quarterly Progress Reports, or other public reports. In some cases, we suggest new measures for which data are not currently collected. Where there is a choice of closely related measures from different data sources, we consider factors such as data accessibility, timeliness, quality, consistency over time, and ability to “drill-down” to subpopulations of interest (e.g., region within the state, or age/income groups) in making a recommendation about which measure and data source to choose.

5.1 Monitoring the Impacts of Policies to Enhance Primary Care Infrastructure

As noted earlier, many of the changes in policy related to health care financing and delivery place a strong emphasis on primary care, and Oregon policy officials have a strong interest in monitoring their impact on the behavior of payers and providers within the state. In particular, there is a strong interest in understanding the degree to which the CCOs and commercial payers invest in activities that support and strengthen the primary care infrastructure. In accordance with earlier sections of this paper, three types of policies that we consider here are: (1) changes in payment policies; (2) supports for primary care practice transformation; and (3) investments to increase the primary care workforce.

Table 1 below summarizes the metrics that we suggest for monitoring these aspects of policies to support and enhance primary care infrastructure. The measures focus on outcomes, rather than processes – in other words, they focus on measures of whether the policy goals are being achieved, rather than intermediate steps toward achieving them.

TABLE 1: MONITORING IMPACTS OF POLICIES TO SUPPORT PRIMARY CARE INFRASTRUCTURE		
Measure	Level of Detail	Data Source
Changes in Payment Policies		
Primary care as a proportion of total spending	Total, Medicaid, and commercial (possibly by individual payer)	CCO reporting, new health plan reporting, and/or All-Payer All-Claims Database

TABLE 1: MONITORING IMPACTS OF POLICIES TO SUPPORT PRIMARY CARE INFRASTRUCTURE		
Measure	Level of Detail	Data Source
Percent of CCO enrollees in a recognized PCPCH*	Medicaid – individual CCOs	CCO quarterly reports
Percent of commercial enrollees in a recognized PCPCH	Commercial – individual payers	New health plan reporting
CCO Alternative Payment Methodology spending on primary care as a percent of total primary care spending	Medicaid – individual CCOs	CCO quarterly reports
Commercial payer innovative payment methodologies: percent of primary care spending that is not FFS	Commercial – individual payers	New health plan reporting
Supports for Primary Care Practice Transformation		
Private payer investments in primary care practice transformation	By type of activity (e.g. EHR adoption, learning collaboratives)	New data collection
Proportion of primary care providers participating in PCPCHs	Provider types: Physicians, physician assistants, nurse practitioners	New data collection via licensing survey
Distribution of PCPCH providers by certification tier		PCPCH Program
Proportion of PCPCHs meeting EHR meaningful use standards		PCPCH Program
Proportion of PCPCHs participating in clinical information exchange		PCPCH Program
Investments to Increase the Primary Care Workforce		
Total number of primary care providers practicing in Oregon	Provider types: Physician, nurse practitioner, physician assistant	Oregon Health Care Workforce Database
Percent of newly licensed physicians entering primary care		Oregon Health Care Workforce Database
Retention rate – percent of primary care trainees who remain in Oregon to practice		New data collection or AMA Physician Masterfile/American Association of Medical Colleges
Retention/turnover rate of providers in health professional shortage areas and medically underserved areas	Provider types: Physician, nurse practitioner, physician assistant	Oregon Health Care Workforce Database

*Measure is also used in Health System Transformation Quarterly Progress Report.

Changes in Payment Policies

As detailed in the discussion of policy options, a range of payment strategies is available to shift health care resources toward primary care and strengthen the primary care infrastructure. These include

strategies such as increasing primary care payment rates, along with more fundamental payment reforms such as care coordination payments for patients receiving care in medical home models or shared savings models that emphasize prevention of the need for high-cost care by focusing on providing better access to high quality primary care services.

The measure for *primary care as a proportion of total spending* illustrates in a relatively simple way the growth in primary care spending compared to total spending, and serves as an overall measure of the resources being devoted to primary care vs. other types of services. Ideally, the numerator of this measure should include all payments to primary care providers, even those that may not be reported through the state’s all-payer all-claims database (e.g., quality performance payments). Although the denominator of this measure can be affected by factors unrelated to policies that promote primary care, nonetheless the measure provides a good “big picture” view of relative resources devoted to primary care. If the state chooses to pursue an approach similar to Rhode Island’s model for holding commercial payers responsible for increasing their primary care spending, then the metric should be tracked and reported by individual commercial payer.³⁵ In addition to understanding the proportion of total spending that is primary care, measuring primary care spending that is taking place under innovative payment mechanisms will be of significant value to understanding system trends. As currently reported by CCOs, the measure for *alternative payment methodology spending on primary care* includes all payments to providers that are made on a basis other than fee for service. An analogous measure for the private insurance market that is analogous to the alternative payment methodology metric for CCOs (*commercial payer innovative payment methodologies – percent of primary care spending that is not fee for service*) would further enhance the state’s ability to understand the degree to which there has been multipayer adoption of innovative payment methodologies.

Of the suggested measures in Table 1, only one – percent of CCO enrollees in a recognized PCPCH – is currently available through existing data sources. The state’s all-payer all-claims database could be used to calculate the measure of primary care as a percentage of total spending,³⁶ but ideally would be supplemented with additional information on non-claims payments. This information is currently reported by CCOs for Medicaid enrollees, but is not limited to primary care;³⁷ since it is reported separately for each provider, however, it may be possible to separate primary care from other types of alternative payments (unless there is significant “roll-up” reporting of providers from within integrated health systems). Both the enrollment and spending measures for the commercial market would likely require some type of new data collection from commercial health plans.

5.2 Supports for Primary Care Practice Transformation

Numerous strategies to support primary care practice transformation are being used by the state and other stakeholders. These include the use of practice management consultants and practice facilitators, incentives and support for adoption of electronic health records, learning collaboratives, and other strategies. The measures listed in Table 1 could be used to monitor the level of support for primary care practice transformation among private payers, and more broadly progress toward achieving greater ability to provide care in a coordinated, efficient manner.

If the state wishes to monitor the degree to which private payers are investing in primary care practice transformation supports, a measure of the level of resources devoted to this activity will be needed (*private payer investments in primary care practice transformation*). It could also include separate measures by type of investment, such as support for EHRs, clinical information exchange, learning collaboratives, and other practice transformation activities. Another important policy goal is for clinics to build on and enhance their capabilities to provide PCPCH services to their populations over time; the *distribution of PCPCH providers by certification tier* measure would track the percentage of PCPCHs certified at various levels over time, to monitor progress toward enhanced primary care practice capabilities. The measures *proportion of PCPCHs meeting EHR meaningful use standards* and *proportion of PCPCHs participating in clinical information exchange* would track progress toward making better use of health information technology to improve and coordinate care.

Most of the primary care practice transformation measures listed in Table 1 listed above are proposed to come from data that is collected as part of the PCPCH certification process. New data collection would be needed for the measure of health plan investments in primary care transformation. For the share of providers who participate in PCPCHs, the licensing survey could be modified to collect this information. For the EHR and clinical information exchange measures, we recommended limiting the metrics to PCPCHs for reasons of data availability; although some other measures exist (such as the measure in the Health Care Transformation Quarterly Progress Report on providers who qualify for meaningful use payments) they are not restricted to the primary care universe. Using the PCPCH universe ensures that the measure is primary care specific; however, a tradeoff is that not all primary care providers are included.

Investments to Increase the Primary Care Workforce

Investments to increase the primary care workforce include strategies directed at training programs (capacity and or types of programs), strategies for addressing shortages in specific regions, and strategies related to licensing and scope of practice. We recommend two measures related to primary care provider retention. First, significant public funds are spent on training medical students, and the greatest return on those investments is achieved when graduates practice in the state where they were trained. Measuring the percent of primary care provider trainees who practice in Oregon upon completion of their training (*percent of primary care trainees who remain in Oregon to practice*) will provide an indicator of the return on public investment in the primary care workforce. In addition, measuring the degree of turnover in the provider workforce in provider shortage areas (*retention rate of providers in health professional shortage areas/medically underserved areas*) will help policy officials understand the impacts of policies to address shortages and more about the underlying dynamics of the shortages (whether they are primarily related to recruitment, retention, or a combination of these factors).

With the exception of the measure related to primary care trainees remaining in the state to practice, the measures related to workforce investment are proposed to come from Oregon's Health Care Workforce Database. The percentage of newly licensed physicians entering primary care could be determined based on data provided at the time of initial licensing, while the retention rate in health workforce shortage areas would require longitudinal analysis of the workforce database. The measure

related to primary care trainees remaining in the state to practice could be calculated from new Oregon-specific data collection, or using the American Medical Association (AMA) Physician Masterfile (a similar measure that is not specific to primary care is published by the American Association of Medical Colleges in its State Physician Workforce Data Book³⁸).

5.3 Monitoring Primary Care System Performance

In addition to monitoring the impact of investments to strengthen Oregon’s primary care system, state officials have an interest in monitoring the performance of the primary care system generally. Table 2 below summarizes the metrics that we suggest for monitoring primary care system performance. For most if not all of these measures, it may be of interest to monitor by region within the state where possible.

TABLE 2: MONITORING PRIMARY CARE SYSTEM PERFORMANCE		
Measure	Level of Detail	Data Source
Utilization		
Primary care visits / 1,000 population*	Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database ³⁹
New patient primary care visits/1,000 population	Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database
Primary care visits for those with chronic conditions / 1,000 population	Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database
Distribution of primary care services by provider type	Provider type: Physician, physician assistant, nurse practitioner Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database
Utilization per 1,000 population by type of service*	Service type: Primary care, specialty care, inpatient hospital, ED, outpatient, and total utilization Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database
Utilization for enrollees in PCPCH compared to non-PCPCH	Service type: Primary care, specialty care, inpatient hospital, ED, outpatient, and total utilization Payer: Total, Medicaid, and commercial	All-Payer All-Claims Database
Cost		
Primary care as a proportion of total spending	Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database, possibly supplemented with new/existing reporting on non-FFS spending for CCOs and commercial payers

TABLE 2: MONITORING PRIMARY CARE SYSTEM PERFORMANCE

Measure	Level of Detail	Data Source
PMPM spending by type of service*	Service type: Total spending, primary care, specialty care, inpatient hospital, ED, outpatient hospital Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database, possibly supplemented with new/existing reporting on non-FFS spending
Distribution of primary care spending by provider type	Provider type: Physician, physician assistant, nurse practitioner Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database
Spending for enrollees in PCPCH vs non-PCPCH	Service type: Primary care, specialty care, inpatient hospital, ED, outpatient, and total spending Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database
Cost of potentially avoidable hospital admissions and ED visits	Payer: Total, Medicare, Medicaid, commercial	All-Payer All-Claims Database
Access/Workforce		
Proportion of primary care providers accepting new patients*	Provider type: Physicians, physician assistants, and nurse practitioners Payer: Medicare, Medicaid, Commercial	Oregon Health Care Workforce Database
Percent of individuals with a usual source of care	Total population and by type of insurance	Oregon Health Interview Survey
Type of place for usual source of care	Total population and by type of insurance	Oregon Health Interview Survey
Ability to get timely appointment*	Total population and by type of insurance	Oregon Health Interview Survey
Percent of population living in primary care shortage designation areas (HPSAs, MUAs, etc.)		Census Bureau, Health Resource and Services Administration (HRSA)
Quality		
Potentially preventable hospitalizations (PQI 90)*	Payer: Total, Medicare, Medicaid, Commercial	All-payer all-claims database or hospital discharge data
Potentially preventable hospitalizations for certain acute conditions (PQI 91)*	Composite measure for dehydration, bacterial pneumonia, and urinary	All-payer all-claims database or hospital discharge data

TABLE 2: MONITORING PRIMARY CARE SYSTEM PERFORMANCE		
Measure	Level of Detail	Data Source
	tract infections	
Potentially preventable hospitalizations for certain chronic conditions (PQI 92)*	Composite measure for diabetes, congestive heart failure, hypertension, angina, chronic obstructive pulmonary disease, and asthma	All-payer all-claims database or hospital discharge data
Hospital readmissions*	Payer: Total, Medicare, Medicaid, Commercial	All-payer all-claims database
Potentially preventable ED visits	Payer: Total, Medicare, Medicaid, Commercial	All-payer all-claims database or hospital discharge data
Preventive care*	Examples: Well-child visits, immunizations, cancer screenings	All-payer all-claims database
Patient satisfaction		CAHPS survey

*Measure is also used in Health System Transformation Quarterly Progress Report or Quarterly Dashboard.

Utilization of Health Services

One important aspect of monitoring primary care system performance is tracking trends in the utilization of primary care services, including trends in overall volume and by type of primary care provider. In addition to tracking primary care utilization overall (*primary care visits per 1,000 population*), separately monitoring the rate of new patient visits (*new patient primary care visits per 1,000 population*) would be useful as a potential indicator of improved access to primary care services. Although the latter measure also captures people who change primary care providers, if this turnover is relatively constant over time then trends in the measure overall would represent shifts in access. An additional useful measure would be *primary care visits for those with chronic conditions*.

Monitoring utilization more generally by type of service (*utilization per 1,000 population by type of service*) would primarily be useful for comparing trends in primary care utilization to other types of service, and especially for understanding whether utilization of other services is increasing or decreasing with changes in primary care utilization. And finally, the measure *utilization for enrollees in PCPCH compared to non-PCPCH* will be useful in evaluating how the spread of the PCPCH model is influencing care patterns.

Utilization rates of primary care and other services are already being tracked and reported on in the Health System Transformation Quarterly Progress Report (for CCOs) and the OHPB Quarterly Dashboard (using the All-Payer All-Claims Database). The state's all-payer all-claims database could also be used to calculate other proposed measures above, including primary care visits for new patients and patients with chronic conditions, proportion of care provided by primary care provider types, and utilization in PCPCH vs non-PCPCH settings.

Cost

One goal of policies to invest in primary care infrastructure and promote greater use of primary care is to contain health care cost growth by providing services in less expensive settings where appropriate and avoiding expensive complications of conditions that can be safely treated and managed in primary care settings.

Similar to the utilization measures for tracking utilization by type of service and in PCPCH vs non-PCPCH settings, we recommend cost measures (*primary care as a proportion of total spending, PMPM spending by type of service, distribution of primary care spending by provider type and spending for enrollees in PCPCH vs. non-PCPCH*) that provide a frame of reference and context for understanding shifts in patterns by type of service and by care delivery model. In addition, the measure for *cost of potentially avoidable hospital admissions and ED visits* provides an indicator of the potential savings from reduced rates of avoidable hospital admissions and ED visits, both of which are believed to be strongly associated with appropriate access to and use of primary care.

Each of the cost indicators listed in Table 2 can be calculated using Oregon's All-Payer All-Claims Database, although it may be desirable to supplement this information with other data on non-claims payments (e.g., quality incentives, shared savings payments) that are not captured in the database.

Access/Workforce

Expansions of access to health insurance coverage and greater emphasis on models of care that have primary care as a focal point make it critically important to understand the degree to which Oregonians have access to primary care services, including whether the existing workforce is adequate to meet demand for services. For example, the measures for *proportion of primary care providers accepting new patients* and *ability to get timely appointment* serve as indicators of potential problems with patients' ability to access care. They are indicators of potential capacity problems systemwide, but are also important to monitor by payer type since access to providers is a particular concern for the Medicaid population.

The access and workforce measures listed in Table 2 would come from a variety of data sources. The Oregon Health Workforce Database collects data on the proportion of providers accepting new patients overall and by payer type, and this measure is already reported for the Medicaid population in the Health System Transformation Quarterly Progress Report. The Oregon Health Insurance Survey collects data on usual source of care and timely access to care. Although the Health System Transformation Quarterly Progress Report includes a measure of timely access to care for CCO enrollees that is based on the plan-level CAHPS survey, we recommend the OHIS measure (which is included in the Oregon Health Policy Board Dashboard) because it includes the entire state population and can be monitored separately by insurance coverage type; however, neither of these measures is specific to primary care. Finally, the measure of population in workforce shortage areas would be calculated using county population estimates from the U.S. Census Bureau and data from the Health Resources and Services Administration on which counties are included in shortage areas.

Quality

The shift toward a model of health care that is more centered on primary care is intended to improve the quality of care, both by reducing rates of unnecessary utilization and by providing a more patient-centered model of care that emphasizes coordination and prevention.

Potentially preventable hospitalizations are hospital admissions that evidence suggests could have been avoided with better access to high-quality outpatient care. The measures suggested in Table 2 are widely-used measures from the Agency for Healthcare Research and Quality's Prevention Quality Indicators measure set.⁴⁰ *Hospital readmissions* are frequently used as another indicator of problems with access to high-quality outpatient care, including primary care. Our suggested measure would be defined as the percentage of adult patients who had a hospital stay and were readmitted for any reason within 30 days of discharge. Finally, the suggested measure for *potentially preventable ED visits* uses a definition of avoidable ED visits developed by California's Medicaid program to measure ED visits for problems that could have been appropriately managed within 24 hours at a primary care physician's office, a clinic, or other ambulatory setting.⁴¹

Although primary care plays a role in the problems of preventable hospitalizations, hospital readmissions, and preventable ED visits, these measures are not exclusively related to the quality of primary care. *Preventive care* measures such as rates of receipt of well-child visits, immunizations, and cancer screenings are direct measures of the degree to which primary care providers are performing recommended care. Due to the ongoing work of the HB 2118 Quality Metrics Work Group, we do not recommend specific measures here; once that work is completed, the state may want to select a limited number of measures related to the quality of preventive care for inclusion.

Patient satisfaction is also an important dimension of quality that should be monitored over time. Data on patient satisfaction specifically with primary care is not systematically collected in Oregon, and would require a substantial investment and new reporting burden on providers. An available alternative is the overall measure of satisfaction with a patient's health plan from the CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey, but this measure is not specific to primary care.

The measures for potentially preventable hospitalizations, potentially preventable ED visits, and hospital readmissions can be calculated from the state's All-Payer All-Claims Database. The preventable hospitalizations measures are included in the OHPB Dashboard, and the readmissions measure is included in the Health System Transformation Quarterly Progress Report. The measure of potentially preventable ED visits is included in the Oregon Health Care Quality Corporation's 2013 Statewide Report on Health Care Quality, along with the preventable hospitalization and readmission measures.

Many preventive care measures can also be calculated from the All-Payer All-Claims Database; an advantage of using this data source is that there is no additional burden on providers, but the measures are generally more related to processes of care rather than outcomes. Finally, the ideal patient satisfaction measure for monitoring primary care system performance would come from a clinic-specific survey, such as the Clinician and Group CAHPS survey (CG CAHPS). However, this data is not currently collected on a widespread or uniform basis in Oregon. An alternative measure would be the

overall patient satisfaction measure that is currently used in the Health System Transformation Quarterly Progress Report, which measures overall satisfaction with an enrollee's health plan (CCO), and is limited to the Medicaid population.

Conclusion

Oregon's effort to transform its health care financing, delivery and coverage systems includes key investments in primary care transformation and infrastructure, particularly in the development and implementation of a multi-payer PCPCH program and the Patient Centered Primary Care Institute. While the groundwork has been laid for a more effective and robust primary care system, the state acknowledges that new policies and programs are needed to ensure that all payers fund primary care services and supports in a fair and consistent manner.

As described throughout this paper, many policy and measurement strategies exist to support greater multi-payer investment in the state's primary care infrastructure. Oregon can pursue strategies that are both compatible with its existing system and support its vision for the future. The anticipated end result is an enhanced primary care system that produces far-reaching and long-term benefits for the state: re-allocating dollars to more cost-effective health services, improving residents' health, and solidifying Oregon's status as a national model for health care reform and innovation.

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- ³³ See <http://www.health.ny.gov/funding/rfa/1308090430/1308090430.pdf>
- ³⁴ See <http://www.fiercehealthpayer.com/story/blues-horizon-invests-1m-fund-medical-home-nurse-training/2012-02-03>
- ³⁵ Unless policymakers have specific types of services that they wish to reduce in order to "make room" for increased primary care spending, we do not recommend additional measures of primary care compared to specific other service categories (e.g., ratio of primary care spending to emergency department spending); such measures give a more limited picture, are less intuitive, and may be more subject to misinterpretation.
- ³⁶ For purposes of this paper, we assume that the all-payer all-claims database will eventually include Medicaid data and fee for service Medicare claims. (Source: Oregon Health Policy Board Initial Quarterly Dashboard, March 2014)
- ³⁷ <https://cco.health.oregon.gov/RFA/Pages/ContractForms.aspx>, Exhibit L workbook revised, 2/11/2014.
- ³⁸ Available at <https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf>.
- ³⁹ It is our understanding that work is ongoing to improve the ability of the APAC to distinguish services and providers by primary care vs. specialty care and to develop a provider directory that also indicates which providers are certified as PCPCHs. These enhancements are needed in order to track many of the metrics listed in this table.
- ⁴⁰ The measure for acute conditions includes dehydration, bacterial pneumonia, and urinary tract infections. The measure for chronic conditions includes diabetes, congestive heart failure, hypertension, angina, chronic obstructive pulmonary disease, and asthma.
- ⁴¹ Another measure of potentially preventable ED visits that is often used is an algorithm developed at New York University that classifies visits based on degree of urgency and whether the condition was treatable in a primary care setting; however, the measure has many limitations including the fact that it is not clear whether it will be updated for the transition to ICD-10 coding later this year and therefore may not be usable in the near future. AHRQ is also testing a set of measures for potentially preventable ED visits, and so the range of methods for monitoring this utilization may expand in the future.



Oregon Department of Education

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Early Learning Division

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Early Literacy Grants

Grantee	Service Area	Grant Amount
Baker County Community Literacy Coalition	Baker County	\$49,122
Child Care Partners	Hood River, Gilliam, Sherman, Wasco, and Wheeler Counties	\$50,000
Coastal Families Together	Lincoln County	\$50,000
Early Learning, Inc.	Marion County	\$100,000
Deschutes Public Library	Crook, Deschutes, Jefferson Counties; Warm Springs Reservation	\$49,998
Early Learning Multnomah	Multnomah County	\$100,000
Friends of the Children	NE Portland	\$46,211
Frontier Services Early Learning Hub	Grant, Harney Counties	\$100,000
Greater Albany Public Schools	Albany	\$44,976
Lane Early Learning Alliance	Lane County	\$100,000
North Central Education Service District	Gilliam, Sherman, Wheeler Counties	\$49,669
Oregon Child Development Coalition	Malheur County	\$50,000
Oregon Coast Community Action	Coos, Curry Counties	\$50,000
Oregon Children's Foundation (SMART)	Klamath	\$25,778
Portland State University	Statewide	\$49,769
South Central Early Learning Hub	Douglas, Lake Counties	\$99,986
Strengthening Rural Families	Benton County	\$45,549
Umatilla-Morrow Head Start	Morrow, Umatilla Counties	\$50,000
Wallowa County Library	Wallowa County	\$50,000
Yamhill Early Learning Hub	Yamhill County	\$90,118
Total		\$1,251,176

Grants to early learning hubs are noted in bold. Remaining Early Literacy Grant funds will be distributed through round two early learning hubs.

This grant is reaching 20,000 children and families, targeted towards children who meet the definition of 'at risk' and is designed to close access, opportunity, and achievement gaps. Target populations include:

- o English learners and their families
- o Immigrant communities
- o African-American children/families
- o Hispanic children/families
- o Native American children/families
- o Children of migrant/seasonal workers
- o Children/families living in poverty
- o Children/families living in rural/remote communities

Early Learning Kindergarten Readiness Partnership & Innovation Grants

Grantee	Service Area	Grant Amount
David Douglas School District	East Portland	\$333,346
Early Learning, Inc.	Marion County	\$412,918
Early Learning Multnomah	North & Outer NE Portland	\$522,692
Echo School District	Echo	\$29,950
Forest Grove School District	Forest Grove	\$298,394
Frontier Services Early Learning Hub	Grant, Harney Counties	\$51,100
High Desert ESD	Bend, LaPine, Redmond, Warm Springs	\$244,357
Intermountain ESD	Baker, Morrow, Umatilla, Union Counties	\$143,700
Lane Early Learning Alliance	Lane County	\$290,000
Malheur ESD	Baker, Malheur, Wallowa Counties	\$162,640
Neah-Kah-Nie School District	Neah-Kah-Nie	\$72,010
Northwest Family Services	Gladstone, Oregon City	\$176,074
Oregon City School District	Gladstone, Oregon City	\$244,912
South Central Early Learning Hub	Douglas, Lake Counties	\$486,029
Southern Oregon ESD	Jackson, Josephine Counties	\$120,000
Yamhill Early Learning Hub	Yamhill County	\$296,974
Total		\$3,885,096

Grants to early learning hubs are noted in bold. The Early Learning Division will be contracting with Portland State University to conduct a mixed-methods program evaluation of this initiative

This grant is reaching 60,000 children and families, targeted towards children who meet the definition of 'at risk' and is designed to close access, opportunity, and achievement gaps. Target populations include:

- o English learners and their families
- o Immigrant communities
- o African-American children/families
- o Hispanic children/families
- o Native American children/families
- o Children of migrant/seasonal workers
- o Children/families living in poverty
- o Children/families living in rural/remote communities.

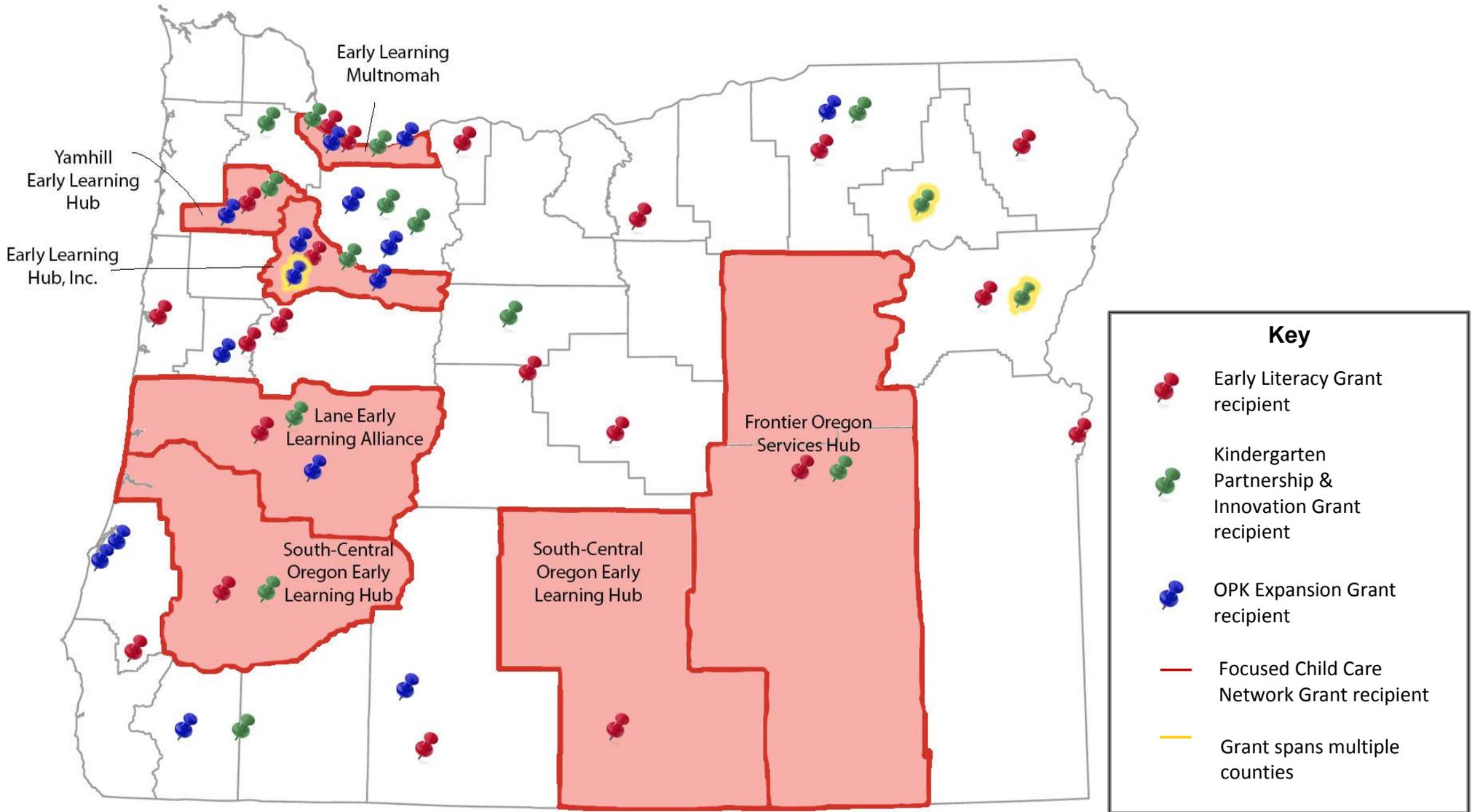
Focused Child Care Network Grants

Grantee	Service Area	Grant Amount
Early Learning, Inc.	Marion County	\$56,117
Early Learning Multnomah	North & Outer NE Portland	\$38,170
Frontier Services Early Learning Hub	Grant, Harney Counties	\$38,170
Lane Early Learning Alliance	Lane County	\$59,9889
South Central Early Learning Hub	Douglas, Lake Counties	\$61,727.40
Yamhill Early Learning Hub	Yamhill County	\$39,025

Oregon Pre-K Expansion Grants

Program	# slots awarded	Funds for Slots Awarded	Demographics (from 2012-13 Program Information Reports)	Expansion Area
Mt. Hood Community College Head Start	60	\$ 523,920.00	HL 49%; B 9%; NA 1%	East Multnomah Co.
Umatilla-Morrow Head Start, Inc.	52	\$ 467,584.00	HL 52%; B 2%; NA 1%	Pendleton, Hermiston
Southern Oregon Child & Family Council	31	\$ 281,635.00	HL 27%; B 2%; NA 1%	Cave Junction
South Coast Head Start	19	\$ 171,798.00	HL 13%; B 0%; NA 4%	North Bend
Clackamas County Children's Commission	34	\$ 289,374.00	HL 40%; B 2%; NA 2%	Milwaukie
Community Action Head Start - Marion & Polk	20	\$ 170,220.00	HL 65%; B 2%; NA 2%	Salem
OCDC	79	\$ 672,369.00	HL 66%; B 1%; NA 5%	40 for Chiloquin in Klamath 19 in Washington Co. (Hillsboro) 20 in Woodburn
OSU Child Development Center	1	\$ 8,511.00	HL 39%; B 3%; NA 3%	Corvallis
Klamath Family Head Start	10	\$ 85,110.00	HL 24%; B 2%; NA 8%	Klamath Falls
Clackamas ESD Prekindergarten	8	\$ 68,088.00	HL 62%; B 1%; NA 0%	West Linn
Head Start of Lane County	20	\$ 170,220.00	HL 31%; B 3%; NA 3%	Springfield
NeighborImpact	3	\$ 27,057.00	HL 29%; B 1%; NA 5%	East Bend
Salem-Keizer Prekindergarten Head Start	20	\$ 170,220.00	HL 51%; B 1%; NA 1%	Fruitland
Head Start of Yamhill County	3	\$ 25,533.00	HL 43%; B 1%; NA 1%	McMinnville
Portland Public Schools Head Start	12	\$ 102,132.00	HL 39%; B 15%; NA 4%	North Portland

Early Learning Investments Across Oregon



Hub Awards

