

CCO Criteria Work Group
November 15, 2011

Discussion Topic: Patient Engagement and Rights/Responsibilities, and Delivery System/Provider Network/Coordination of Care

Carolyn Ingram—Senior Vice President at the Center for Health Care Strategies (CHCS), formerly New Mexico State Medicaid Director as well as Senior Manager with the Lewin Group—presented an overview of key considerations for patient engagement/rights & responsibilities and delivery system transformation. Her presentation

- Patient Rights, Responsibilities, and Engagement in CCOs
- Overview of Beneficiary Protections
- Patient Engagement Tools – some examples include:
 - Shared decision making
 - Patient incentives
 - Provider payment levers
- Revisiting Network Adequacy

Also included in the background materials were

- A Matrix on Patient Engagement/ Patient Rights and Responsibilities, produced by CHCS
- State Options for Integrating Physical and Behavioral Health Care, produced by Integrated Care Resource Center
- Oregon’s Patient-Centered Primary Care Homes Overview, produced by OHA

The work group split into four breakout groups to discuss their ideas and concerns with regards how OHA can assure that CCOs will effectively address patient rights and responsibilities in the context of patient engagement under HST and the Triple Aim, and also how OHA should evaluate the CCO’s ability to assure that the right providers deliver the right care, at the right time, in the right place.

Key Input for Oregon Health Policy Board

Small group discussion provided the following input

Patient Engagement and Rights/Responsibilities

Areas of agreement:

CCOs should determine the best patient engagement approaches and barriers for a particular population by engaging the community and developing a strategy through a community needs assessment.

CCOs need to meaningfully engage their Community Advisory Councils in the innovative development, planning, adoption and monitoring of patient engagement and activation approaches.

CCOs must be prepared to apply a range of strategies when working with diverse members with varying needs within the Medicaid/Medicare/vulnerable populations and to identify the appropriate strategy for a particular population.

Consider three levels of patient engagement: 1) individual level, 2) peer level, and 3) small group and community level.

OHA should provide a clearinghouse of innovations and best practices, including patient engagement and activation tools, for CCOs to choose from and disseminate as appropriate. This includes providing technical assistance and assuming a leadership role in support of a Learning Collaborative among CCOs.

Areas of tension:

Is there a need to define patient responsibility and allow flexibility if the patient does not engage in an expected manner? Should patients have the right to engage as they want, including the explicit refusal of treatment, and should CCOs have a process to strike a balance between clinical indication and patient preference? There may sometimes be a natural tension between evidence-based medicine and patient wants and needs.

Should CCOs develop an education process for patients on using appropriate levels of care?

Should social determinants of health, including the effects of poverty such as social isolation or lack of access to nutritious foods at affordable costs, be accounted for when considering the best

approaches to patient engagement, activation and responsibility? For example, some standard models will only work when a patient has the same resources as a commercially insured patient.

Should the OHA be evaluated on its performance as regulator and for its leadership in innovation and supporting the learning collaborative among CCOs?

Should CCOs have a health wellness program that is ongoing and dedicate a fixed percentage (say 1%) of the global budget for wellness and prevention as a concrete method to focus CCOs on wellness and prevention?

Surprises:

CCOs may wish to employ social marketing to reach out to community.

CCOs should communicate to patients in ways they prefer, whether it's face-to-face, via phone, facebook, email, etc.

CCOs should conduct an upfront assessment of member's capacity for participating effectively in advocating for and coordinating their own care, i.e., a measurement of activation potential.

The OHA could require an innovation/ombudsman officer in every CCO to attend Patient Advisory Council meetings and serve as the main point of contact between OHA and CCO.

CCOs should have an innovation program related to patient engagement, activation or wellness that goes beyond their standard wellness program and addresses at least one broad based health issue (e.g. smoking cessation or drug and alcohol abuse).

Key Input for Oregon Health Policy Board

Small group discussion provided the following input

Delivery System/Provider Network/Coordination of Care

Areas of agreement:

CCOs should identify and describe the specific structure of their delivery system network (DSN) and its ability to provide needed services, i.e., network adequacy, at the outset and goals the CCO has and how they plan to get there.

CCOs should detail how they will maintain access standards for routine and specialized health care services, particularly for the most vulnerable populations.

CCOs should ensure their provider network is broad and diverse, able to provide services across the continuum of care and working in a team approach with multidisciplinary and holistic fashion, when possible.

CCOs should identify and describe how under and over utilization of services, complaints and quality management will be monitored.

Ensure access on a primary care level, where screenings can occur to determine if a higher level of care is needed. Ensure providers are working at the top of their license.

Right time means two things: 1) emphasizing early intervention and prevention, and 2) maintaining flexible hours and other measures to ensure patients can access services and receive care in a timely manner.

Employ the use of telemedicine, especially for those living in rural areas needing access to their provider.

Areas of tension:

Should CCOs start with the sentinel population in their community, i.e., the top 10% most costly members and measure the CCOs improvement for this group on such things as reduced hospital and emergency department use, for example?

Should the CCO DSN plan describe an approach for expected of future Medicaid rate cuts. OHA's expectations for CCOs should also be informed by the likelihood of such cuts?

Concern was expressed about accountability for CCOs, including what authority OHA will have and use and what consequences there will be for poor performance.

Should there be a standard intervention for CCO non-compliance, asking initially if a CCO has done what it said it would and if not, why? What is the plan for corrective action?

Surprises:

CCO's DSN will be able to meet the full vision for CCOs once OEBC and PEBC are included, until then CCO's DSN may be thought of as an enhancement to the existing Medicare and Medicaid delivery system.

The OHA should provide examples of illustrative patient scenarios to CCOs and ask them how they would manage care in a holistic manner for those patients.

CCOs should identify and describe how they will allocate resources from the global budget to maintain and eventually improve current community standards for health care services and or achieve health outcome goals (e.g. reduce unnecessary repeat hospitalizations).

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**Medicare – Medicaid Integration of Care and Services Work Group
November 17, 2011 Meeting Summary**

Discussion Topics

Beneficiary Meetings in December

Co-Chair Judy Mohr Peterson updated the group on several listening sessions to be held during the week of December 12th for individuals who are dually eligible. The purpose of the meetings is to provide beneficiaries an opportunity to provide feedback on the proposed changes under healthcare transformation. Five meetings will be held in the following cities; Portland, Eugene, Bend, Roseburg and Coos Bay. Questions about these meetings should be directed to Brian Nieubuurt, who is the OHA staff member coordinating and organizing these meetings.

Medicare-Medicaid Webinar

Co-Chair Judy Mohr Peterson summarized results of a Medicare-Medicaid integration webinar held Nov. 8th. The webinar was a voluntary opportunity for current health plan providers to identify lessons learned relative to care coordination, transitions of care and coordination of services for people in long term care settings. Participants included: ATRIO Health Plans, Care Oregon, LIPA and Mid Rogue Independent Physician Association. The Webinar has been posted on the Oregon Health Authority YouTube channel (see link from our workgroup webpage).

Strategies for Shared Financial Accountability

Co-chairs Tricia Baxter and Judy Mohr Peterson discussed the need to identify methods by which the CCOs and LTC can be held jointly accountable for the delivery of health outcomes consistent with the Triple Aim. They presented a financial strategies discussion document that detailed three preliminary financial accountability concepts. Preliminary concepts for discussion included 1) financial incentives and/or penalties tied to performance metrics, 2) sharing savings and/or costs compared to spending or caseload benchmarks, and 3) correctly allocating costs between the CCOs and the LTC system. It was noted that these ideas were preliminary and were not exhaustive, and that the Health Authority was seeking the opinions, advice and concerns of the group regarding how financial strategies might be applied to ensure joint accountability between CCOs and the LTC system.

Breakout Groups

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

- ***How should CCOs and the Long Term Care system share financial accountability? In particular, in thinking about the three potential financial models in the handout “CCO/LTC Shared Financial Accountability,” what are your reactions?***

- ***What are the critical elements for holding CCOs and LTC jointly accountable for ensuring that high quality, person-centered care is delivered to beneficiaries?***

Key Points for Oregon Health Policy Board – Shared Accountability between CCOs/LTC

Shared Financial Accountability

Areas of Agreement:

- Tying financial incentives to metrics, and particularly outcomes, is a promising approach toward ensuring that the CCOs and the LTC system work together to provide high quality, person-centered care.
- Need to balance flexibility and prescriptiveness, by focusing on outcomes but letting the CCOs and the LTC system determine how best to reach them.
- Option 3, the “modified Minnesota model” would be too prescriptive and complicated to implement and should not be pursued further.

Areas of Tension/Anticipated Challenges:

- Lack of agreement about whether it was a good idea to focus on spending or caseload benchmarks.
- Concern about tying financial incentives to LTC caseload benchmarks, because caseloads may not be within the CCO’s control, and utilization of LTC services is not a poor outcome.

Surprises:

- Suggestion that public disclosure of provider performance on key metrics could be a potential alternative to formal financial incentives/penalties.

Elements of Shared Accountability

Areas of Agreement:

- Key elements of accountability include: better communication and data-sharing between CCOs and LTC; alignment of state rules and regulations; and tracking of appropriate performance metrics.
- Many of the elements of CCOs and health system transformation previously discussed are also critical for joint accountability, such as care coordination teams and promoting patient engagement.

Areas of Tension/Anticipated Challenges:

- Concern that in promoting system accountability, the focus should be on benefits to individuals and providing person-centered care.

Surprises:

- Suggestion for an administrative or systems-level multi-disciplinary team that meets regularly to identify, assess and address trends, issues and concerns within the broader health system.

Small Group Discussion

How should CCOs and the Long Term Care (LTC) system share financial accountability?

The groups felt that option 1 (financial incentives/penalties tied to metrics) and option 2 (caseload or spending benchmarks with shared savings/costs) were the most appropriate approaches to pursue further.

- The groups generally preferred an approach balancing flexibility and prescriptiveness, and felt that this could be achieved by setting specific expectations through metrics or benchmarks, and then letting CCOs and the LTC system determine how best to achieve them.
- While there seemed to be consensus that tying financial incentives to metrics, and particularly outcomes, was a promising approach, there was less consensus about whether it was a good idea to focus on spending or caseload benchmarks.
- With regards to LTC caseloads in particular, concerns were raised that caseloads were not controllable due to external factors, and that LTC use is not a poor outcome or necessarily avoidable.
- One group thought that public disclosure of provider performance on key metrics could be a potential alternative to formal financial incentives/penalties.

A few specific thoughts were shared about how to structure the financial incentives or shared costs/savings:

- One group addressed the issue of positive incentives vs. penalties, and felt that positive incentives would be a better approach.
- Another group felt that in a shared costs/savings model, the CCO and the local community or LTC providers should have flexibility in helping design how the costs and savings would be shared.

Participants mentioned a number of considerations that should be kept in mind in developing metrics that would be tied to financial incentives/penalties:

- It may be important to adjust metrics for particular CCOs/providers based on patient severity or risk.
- Need to ensure that both parts of the system consider long-term implications, not just immediate cost-savings.
- Metrics should be chosen that focus efforts on the highest cost or highest health impact services, and the factors that are driving their utilization.
- The metrics chosen should be consistent with and support the goal of patient-centered care.

A number of specific metrics were suggested as options that might be tied to financial incentives/penalties, including:

- Reducing potentially avoidable hospitalizations and ER utilization.
- Reducing percentage of client days spent in nursing facility setting.

- Increasing percentage of client days spent in home or community-based setting.
- Improving aggregate ADL scores.
- Reducing population disease burden/early identification and prevention of disease.
- Use of patient-centered primary care home and/or integrated care team; use of preventative primary care.
- Transfer of clinical information between LTC and CCO; LTC reporting of significant change in patient status or condition to CCO/medical provider.
- Medication reconciliation (at care transitions and/or at regular intervals).
- Use of person-centered care planning, consumer-directed services.
- Increasing patient engagement.
- Increasing consumer satisfaction, as measured through surveys.

The groups agreed that option 3 (“modified Minnesota model”) was too prescriptive and complicated and didn’t make sense to pursue further.

- Concerns were raised that it would be difficult to clearly draw a line between which services were medical care and which were LTC, creating confusion and administrative burdens.
- Several participants noted that the MN experience was that this model actually increased NF utilization, which is not a desired outcome.
- However, participants were receptive to some elements of the model, including waiving the requirement for a prior 3-day hospitalization to access skilled nursing facility services, and potentially allowing other LTC provider types to offer these types of services.

What are the critical elements for holding CCOs and LTC jointly accountable for ensuring that high quality, person-centered care is delivered to beneficiaries?

Participants identified a number of elements that could be part of ensuring joint accountability between CCOs and the LTC system, including:

- Better communication between the systems and knowledge and understanding of each other’s programs;
- Appropriate performance metrics (see list above under Q.1);
- Shared data between the two systems to ensure that they have common understanding and shared baseline;
- Ensuring that state rules and regulations, particularly SPD and DMAP rules, are aligned to promote system accountability and don’t create conflicting decisions (for instance, example of special wheelchair that DMAP was not going to pay for, but which would allow individual to stay in their home) ; and
- Flexibility in CCO medical benefit design and flexibility within the LTC system to ensure that total health care needs of clients can be addressed appropriately.
- One group suggested the concept of an administrative or systems-level multi-disciplinary team to meet regularly and identify, assess and address trends, issues and concerns within the broader health system.

In thinking about systems accountability, participants raised several concerns:

- Participants felt that financial accountability models alone will not ensure increased quality of care or better health outcomes, and that specific performance measures tied to outcomes will still be required.
- Benefits to individuals should be the focus of how and why we design models of shared accountability.

The groups emphasized that many of the elements of CCOs and health system transformation that were previously discussed will be critical to ensuring the success of the model, and hence also to joint accountability, including:

- Patient-centered primary care home model, and care coordination teams, including the LTC system on the team;
- Workforce issues – recruitment and retention via training and adequate pay, including for community health workers and peer educators;
- Defining an individual's goals of care, and following a plan of care signed off on by the patient; and
- Promoting patient engagement.

Outcomes, Quality, & Efficiency Metrics Work Group

November 14, 2011 Meeting Summary

Discussion Topics

Tina Edlund and Sean Kolmer gave a summary of Board and public feedback on the group's October meeting and an overview of the timeline for the next steps on CCO development work. Workgroup members also heard a presentation from Dr. John McConnell, Associate Professor of Emergency Medicine at OHSU and member of the Global Budget Methodology Workgroup, on mechanisms for linking quality with payment.

The group subsequently divided into three smaller discussion groups to consider potential options for organizing, staging and implementing CCO accountability. Members were asked to address a range of discussion questions including:

- Should measures be categorized as core, menu, and developmental, as the workgroup has discussed in the past? If so, how should each category be used and what kind of measures should be in which category?
- Should reporting and accountability be phased in over time? If so, how?
- How should OHA approach setting minimum performance expectations and targets for exceptional performance?
- What process of reviewing and updating measures over time would provide reasonable predictability for CCOs?

Key Points for the Oregon Health Policy Board

Consensus

- Core measures should be transformational items from the outset and should include more as time goes on. Similarly, the core set should focus on outcomes, not processes, to allow for innovation at the CCO level.
- In general, workgroup members favored a phased approach for both reporting and accountability and suggested that staging should be CCO-specific rather than uniform across all CCOs. Most emphasized that the staging approach should incent improvement rather than penalize CCOs prematurely, since CCOs may be coming from different starting points.
- In general, members advocated for CCO choice among developmental (or transformational) measures.

Areas of disagreement

- Some members advocated for strict exclusion of process measures from the final set of accountability metrics, arguing that process measures would stifle innovation and were

more appropriately used internally to the CCO and at the practice level. Other members felt that process measures may be useful initially (if explicitly tied to a desired outcome), in cases where the outcome is too far in the future to capture, or for regulatory accountability.

Surprises

- None noted.

Linking Quality and Payment Presentation

Dr. McConnell emphasized the following as important considerations for designing a quality incentive program:

- The right amount of reward payment;
- Selecting high-impact performance measures;
- Structural designs, e.g. making payment reward all high-quality care by setting up multiple thresholds (thus avoiding distorted incentives in the all-or nothing approach), rewarding improvement as well as achievement, and rewarding for each patient that receives recommended care
- Prioritizing quality improvement for underserved populations.

Dr. McConnell presented Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract as an illustrative model of quality incentives.

Small Group Discussion

Comments on organizing or categorizing measures

- Most members expressed support for the core and developmental categories of measures discussed in past meetings. The menu category received less support.
 - Two groups questioned the value of a menu category. One saw "menu" as more of a process than a distinct category. Another felt that CCO populations and mechanisms of care would be relatively comparable, so that the need for a menu set would be minimal.
 - One group suggested that the core set should include one developmental measure of the CCO's choosing (as long as that measure was not something the CCO was already measuring or something the CCO had already addressed).
 - One group objected to the term "developmental," arguing that it was too vague and did not connote a strong sense of accountability. This group suggested using the term "transformational" for this category instead and expressing the measures in this category as goals.

- Members made a variety of suggestions for which measures should be in which category. In general, there was a consensus that many measures listed as developmental on the straw document should be candidates for the core set instead. The core set should include transformational, outcome-oriented measures from the outset.
 - More than one group suggested that the developmental set should focus on care coordination between medical and non-medical systems or outcomes that are generally considered outside the “turf” of healthcare (e.g. improved housing stability). State assistance may be required to help CCOs access the data related to non-healthcare outcomes.
 - Similarly, some members suggested that developmental measures should focus on transitions of care and social determinants of health.
 - However, some members cautioned against including items that CCOs (will) have limited experience in measuring on the core set.
 - One member suggested that the core set include cost and efficiency measures.
- As in the past, members expressed a preference for outcome measures whenever possible. Any process measures used initially should have an explicitly stated link to the eventual outcome. (One group felt strongly that OHA should not mandate any process measures; CCOs should determine those themselves.) However, workgroup members noted several considerations that they felt would be important when using outcome measures. Comments included:
 - There is a need to ensure adequate denominators for outcome measures, so that outcomes don’t look artificially good because only 25% of the member population is included. Denominators should be specified by OHA, not CCOs. However, even claims data may not provide adequate denominator data since they will not reflect members who did not seek care.
 - Some outcomes take too long to show up or to measure, so take care to select outcome measures that are feasible and actionable in a reasonable timeframe.
 - There is a need to account for variation of health status and disease prevalence across different population groups (e.g. diabetes, hypertension) when using outcome measures. Normalizing data is one option in terms of addressing race/ethnicity differences that may impact certain outcomes but existing data systems may not capture race, ethnicity and other factors adequately to allow for this.
- In general, members advocated for CCO choice among developmental (or transformational) measures based on community need and CCO-specific target populations.
 - However, some members felt that CCOs should be discouraged from choosing the “easiest” measures or measures on topics that CCOs were already addressing.

- Another noted that, while CCOs should choose developmental measures, those measures should be standardized across the healthcare and non-healthcare partners in the CCO service area.
- One group suggested that OHA group potential measures by issue or population so that CCOs can choose those most relevant to the issues or populations they are trying to address (e.g. homeless individuals).
- The same group encouraged flexibility for CCOs to determine how they will coordinate with community partners to achieve health outcomes or address social determinants of health. The group advocated for shared accountability/responsibility for transformational metrics with community partners (e.g. public health), noting that CCOs should not be at risk when community partners do not have “skin in the game.”
- Workgroup members also discussed the movement of measures from one category to another.
 - There may be value in using the menu set as a “feeder” mechanism for the core, if both sets are fairly small and constrained to topics of state interest.
 - One group suggested moving measures in a stepwise process from developmental, to menu, to core (in a process analogous to Meaningful Use).
- Not all groups discussed how many measures might be appropriate for each category. However, most members expressed support for a small set of measures overall (e.g. 12 or 15). Some noted that rate cuts may limit CCO capacity for measurement or transformation.

Comments on staging

- In general, workgroup members favored a phased approach with accountability for reporting at the beginning and accountability for performance later. Groups offered a range of suggestions for staging, such as:
 - Year one is data collection with no adjustments for performance; in year two, CCOs would be paid for improvement against their own standards, and in year three, each CCO would be measured against absolutes, with the possibility of penalties.
 - Initial accountability could include some baseline, regulatory items (minimum standards for market entry) but is largely “professional;” that is: OHA tells CCOs where they should be heading but leaves it to CCOs to determine how best to get there. The next step would be to determine CCOs’ reporting ability, and then move to incentives for performance improvement.
 - Staging for CCO metrics should be tied to progress on implementation of patient-centered primary care homes (PCPCHs). E.g. CCOs establish baseline for PCPCH implementation based on how many enrollees in CCO are connected to PCPCH

and the health status of those individuals; OHA uses that baseline as benchmark to measure future CCO efforts at PCPCH implementation across their network.

- Members generally advocated for CCO-specific staging, rather than a single staging plan applied across all CCOs. The most common rationale for this position was that CCOs will start in different places; some may be entirely new entities or partnerships while others will be used to working together and already have infrastructure in place for collaborating, performance improvement, or reporting.
 - However, one group noted that there should be some kind of “not to exceed” date so that all CCOs would come up to the same minimum level of performance within a reasonable timeframe.
- One group commented that 6 months from start-up was too soon to expect reporting but suggested that it might be a feasible start for a reporting period (i.e. so that first results might be 18 months from start).

Comments on performance standards

- Similar to comments on staging (see above), many workgroup members argued that achievement of minimum standards should be phased in using a timeline specific to each CCO.
- More than one group suggested that performance standards should be developed from the initial rounds of CCO performance data. OHA should communicate clearly to CCOs that performance standards will be developed over time.
- More than one member emphasized the importance of risk adjustment when applying performance standards. Members advised OHA to account for medical co-morbidities as well as demographic and social factors like language, race, ethnicity, mental health status, A & D status, etc.
 - One member argued that risk adjustment will be necessary across the board, not just for outcome measures
 - Members also noted that both the tools and data sources for risk adjustment must be standard across the state
- It was suggested that using improvement over time (rather than absolute benchmarks) may be an appropriate way to address disparities and differences in CCO starting points.
- However, another group commented that benchmarking in Medicare has allowed providers to game the system by low-balling early numbers in order to show improvement over time.

Comments on incentives

- In general, members seemed supportive of offering incentives for CCO performance, particularly CCOs' success in meeting transformation goals. Members also advocated for offering performance rewards first and penalties later.
- One group noted that public reporting could provide a strong, non-financial incentive for performance improvement.
- Another noted that metrics alone, particularly process measures, will not drive innovation. Metrics must be strongly associated with accountability.
- One group suggested that OHA provide technical assistance and perhaps an up-front incentive to help CCOs make progress on developmental measures.
- One group suggested that there seemed to be three different kinds of accountability:
 - Professional accountability – Set the expectation for where we want CCOs to go and let them determine how to get there
 - Financial incentives and disincentives – that reward or punish adherence to expectations and outcomes accordingly
 - Regulatory – baseline with enforcements that come later

Comments on reviewing and maintaining CCO performance measures

- Many members emphasized the importance of ongoing evaluation of the appropriateness and effectiveness of measures being used. The expectation is that the core and other measures will evolve over time.
 - Evaluation process should be system-wide with representatives of CCOs and other stakeholders including consumers and community partners.
 - More frequent, less onerous feedback loops will be important during transformation. OHA shouldn't wait one year to get feedback. There will be a lot of unique growth; OHA will need to know what is working and what is not.
- Many also suggested that OHA evaluate the resources required for measurement and for CCOs to achieve improvement (e.g., how many FTE were needed? Is it cost effective?)
- There should be a rapid cycle improvement process which will be important for CCOs to understand and be engaged with. Some CCOs may need technical assistance for planning and implementation of elements of the rapid cycle improvement, and advice on how and when to consider improvements (i.e. you can't wait 3 years to do x, y, z)

Miscellaneous Comments

- As in the past, several members stated that CCOs should be required to have quality improvement plans and goals in place and to demonstrate improvement over time.

- However, one group strongly encouraged OHA to seek a waiver from existing Medicaid and Medicare quality improvement program requirements, arguing that they were burdensome and would weaken transformation efforts.
- As in past meetings, workgroup members noted that the mobility of CCO members and “churn” on and off Medicaid is a key consideration for accountability. It may be very difficult to “put a fence around” CCO target populations.
- One group suggested that CCOs be required to conduct active outreach and perhaps participate in case management for to ‘hard to enroll’ individuals – Medicaid eligible individuals who do not enroll but nevertheless consume high cost services. Group members argued that CCOs should be held accountable in some fashion for all Medicaid eligibles in the service area, not just those enrolled with the CCO.

Global Budget Methodology Work Group November 14, 2011 Meeting Summary

Discussion Topics: Program Inclusion & Financial Savings Framework

Program Inclusion in CCO Global Budgets. Direction from Oregon Health Policy Board (OHPB):

- Get as global as possible to strengthen accountability and transformation
- Funding included should be outcome-focused (e.g., care coordination and prevention)
- Funding and methodology should be transparent
- Local flexibility and innovation should be supported
- Use of local funds should not be jeopardized
- Communities work with stakeholders to build comprehensive proposals

Strategies included in framework for estimating financial savings:

- Patient-Centered Primary Care Homes
- Coordinated physical, mental and oral health
- Coordinated care for individuals who are dually eligible for Medicare and Medicaid
- Shared accountability between acute and long term care
- Alternative payment methodologies
- Broad adoption of evidence based guidelines
- Expanded use of electronic health records

Key Feedback for Oregon Health Policy Board

Program Inclusion: Based on the OHPB feedback, how would you define what Medicaid programs / funding is included in the initial global budgets?

Areas of agreement:

- All groups agreed that CCO global budgets should generally include as many programs as possible, but should avoid compromising local financing or overall service capacity for both Medicaid and non-Medicaid beneficiaries.
- Several workgroup members expressed concern regarding mental health drugs and long term care carve outs. Shared accountability mechanisms are needed to align incentives in order to promote effective and efficient person-centered care and reduce the incentive to cost shift.
- Accountability metrics need to be in place for programs included in CCO global budgets to ensure that the CCO is carrying out the aims of the program.

Areas of tension:

- Diverse opinions were expressed regarding including FQHC wrap around payments and the CAWEM Prenatal program in initial CCO global budgets.
- Several members noted that although there is a preference for not disrupting existing relationships in place to fund and manage programs, this may perpetuate inefficiencies.

Surprises:

- Managing churn (on and off Medicaid and potentially between CCOs) and enabling information sharing between settings and systems will be critical to CCOs' ability to coordinate care and achieve outcomes, and is therefore critical infrastructure to enable broad program inclusion.

Savings Assumptions: What assumptions are we missing or should be adjusted?

Areas of agreement:

- Robust Patient-Centered Primary Care Homes are critical. They should incorporate non-traditional health workers and stress patient engagement.
- Social determinates of health must be addressed.

Areas of tension:

- Although electronic health records (EHRs) were acknowledged as an important component of the financial savings framework, concern was expressed as to how to fund their implementation. While interoperability is important, there may be a value in getting EHRs off the ground first and then working on interoperability.
- It is important to reduce administrative burden of oversight activities, but there is also a need to provide CCOs flexibility to innovate, which may make responsible oversight more difficult.

Surprises:

- Although small group discussions varied to a considerable degree, all three break out groups stressed the importance of patient activation and engagement in realizing savings.

Small Group Discussion

1. Program Inclusion: Based on the OHPB feedback, how would you define what Medicaid programs / funding is included in the initial global budgets?

Exclusion Criteria

Each group advocated for rolling as many programs/funding streams into the global budget as possible because there is a value in having CCOs manage Medicaid dollars. However, each group also stressed the importance of maintaining local financing for health programs and the overall local capacity to provide services (to both Medicaid and non-Medicaid clients) is not compromised. Other reasons mentioned for potentially not including a program included:

- When a state-wide strategy is more efficient than local implementation. For example, pass through payments to CCOs, such as Medicare premiums for individuals who are dually eligible for Medicaid and Medicare, may be managed more efficiently by the state or another centralized entity.

- Programs or funding streams currently administered by the state may need to be excluded if CCOs do not know how to go out and purchase that function or capacity.

Including Mental Health Drugs and Long Term Care

While acknowledging related provisions of house bill 3650, all three groups brought up the importance of including mental health drugs and long term care or at least developing shared accountability mechanisms to align incentives in order to promote effective and efficient person-centered care and reduce the incentive to cost shift (e.g., substituting mental health drugs for ambulatory care when the latter may be more suitable).

Program Inclusion Should be Paired with Metrics

Several groups noted that program inclusion needs to be paired with metrics to make sure that CCOs are carrying out the aims of the program rather than simply redirecting a funding stream. One group suggested that CCOs should be required to cover a benefit (e.g. adult residential mental health) if and when it is needed but that they should have the flexibility to use funds in a different way to prevent the need for that benefit or to enhance it.

Opinions Vary Regarding FQHC Wraparound Payments and CAWEM Prenatal

Two groups explored diverse opinions around including wrap around payments for Federally Qualified Health Centers (FQHCs) and the Citizen Alien-Waived Emergency Medical (CAWEM) Pre-Natal programs. With regards to FQHCs, members of various groups expressed concerns that CCOs may lack the understanding and capacity to pay FQHCs, and that this may jeopardize federal funding. Others felt that including FQHC payments in CCO global budgets could allow for innovation. One group generally agreed that FQHC services should be included but phased-in over time to give CCOs time to develop the necessary expertise. With regards to CAWEM Pre-Natal program, several group members were very concerned about maintaining the program and felt that it should stay separate from CCOs, since there is a significant local match that might well be lost. Another workgroup member suggested that the program should be included in CCO global budgets because they would likely become responsible for the health care needs of newborns delivered under the program.

Additional thoughts that emerged from workgroup discussions

- One group noted that information sharing will be critical to enabling coordination and several argued that the state is not supporting anything significant in this area. They felt that the primary need is not an IT solution but policies that enable streamlined information sharing between providers, programs, and CCOs, if necessary.
- One group noted that reinsurance or risk pooling may be needed in order to include programs that target high risk beneficiaries.

- Several group members suggested that some non-Medicaid social services should be included in CCO global budgets, and that the governor's Early Learning Initiative could potentially be incorporated into CCOs.

2. Savings Assumptions

The small group discussions of the CCO Financial Savings Framework included reemphasis of strategies in the framework that were considered important, additional strategies that some felt should be included or considered, and additional considerations.

Patient-Centered Primary Care Homes

One group noted that patient-centered primary care homes should include not just an increase in provider capacity, but also the use of other provider types and a more comprehensive, robust approach to primary care including patient engagement and activation. Another group stressed the need to move beyond the medical model to address the social determinants of health and emphasize wellness and prevention.

Expanded use of electronic health records

One group raised concerns about the costs of implementing electronic health records, and where the funding is going to come from, what it takes to make it happen. There was also a concern about making sure that the work is coordinated with the state-wide Health Information Exchange/HITOC efforts. While interoperability of EHRs was acknowledged as a key element, one member pointed out that there are benefits to getting EHRs implemented and that interoperability could be tackled down the line.

Administrative Burden

Two groups stressed the importance of eliminating unnecessary administrative burden in order to realize financial savings. One group member said that it was the state's responsibility to define a series of meaningful and actionable global health outcomes that it wants to pay for, and then to subtract out all the requirements that distract from achieving those outcomes. Suggestions for steps the state can take to remove administrative burdens included:

- streamlining financial reporting requirements with DCBS;
- enabling single financial audits rather than multiple reviews of the same data by different parties;
- and not penalizing entities for providing services that can't be claimed (e.g. health education class).

Errors and Duplication

One group noted that reduction of errors and duplication had greater potential for savings than may be widely recognized (e.g., through more efficient use of lab, imaging, and other diagnostic services).

Fostering Innovation

One group wrestled with the tradeoff between CCO standardizing and innovation. Standardizing CCO services would provide clients consistency across programs and reduce the cost of administration and oversight whereas providing flexibility would allow CCOs to innovate. The group felt that the need for innovation was stronger than the need for standardization, but that there may be a role for the state to help surface and disseminate successful innovations.

Additional thoughts that emerged from workgroup discussions

- It is important that the financial savings framework include a feedback loop that enables CCOs to adjust their strategies in accordance with their ongoing experience.
- There also was discussion of concerns about access to care, particularly for primary care and mental health, but also more broadly, including problems resulting from too little capacity as new cohorts become eligible for coverage.
- The savings framework should add as a factor the timing of savings from improved outcomes.
- It was noted that the addition of PEBB and OEBC to health systems transformation and enrollment in CCOs might substantially strengthen the possibilities for CCO expansion and for financial savings.
- Given the aggressive savings targets, it is important to spell out what will occur if they are not realized.