

## **1-Paragraph Summary of each of the September Transformation Workgroups**

### **9/20/11 Global Budget Methodology Work Group Meeting**

Global Budget Methodology Work Group members discussed their concerns about financial risk and ways to address those concerns. Carolyn Ingram, Senior Vice President at the health policy institute the Center for Health Care Strategies, presented examples of innovative Medicaid risk-sharing arrangements that other states have with their Medicaid plans. Work Group members pointed out that managed care organizations in Oregon have successfully handled all of the financial risk for their members, but CCOs may face challenges in taking on additional risk. Members also stressed that any risk-sharing arrangement with the state should last several years so that CCOs can make upfront investments to improve health care systems and then realize savings over time. Finally, work group members emphasized that outcomes should play a central role in risk-sharing arrangements. They felt that CCOs should demonstrate progress towards providing high quality coordinated care in order to share financial risk with the state.

Next Meeting: Monday, Oct. 17

Location: Cherry Tree Training Center, Salem, OR

### **9/21/11 CCO Criteria Work Group Meeting**

The CCO Criteria Work Group members discussed the most important aspects for the OHA to consider related to health equity as well as CCO governance and community engagement. This input is important to define CCO certification criteria, and ways that OHA might evaluate CCO strategic approaches and monitor success in meeting health systems transformation policy objectives. Regarding health equity, there was general agreement that the issue should be broadly framed, with race and ethnicity addressed in combination with such factors as age, gender and sexual orientation, income level, and rural/urban location. There was also agreement that while OHA might provide some state/regional level data, it would fall to the CCO to assess health disparities in its service area and to develop strategies for reducing these disparities based on that community assessment. It was also noted that substantial reduction in health disparities will depend on the representation of a region's diverse communities in the CCO's governance and community engagement processes. Transparency and accountability of governance were deemed crucial, as well as clearly defining the responsibilities and representation on the CCO boards and how that relates to risk sharing and financial relationships. In particular, accountability of the governing board to the community advisory council was identified as critical - including assurances that recommendations be fully considered, with feed-back on actions taken or deferred. Regarding values, it was noted that safeguards may be needed to assure that community values do not infringe upon appropriate access to health care covered through CCOs.

Next Meeting: Tuesday, Oct. 18

Location: Cherry Tree Training Center, Salem, OR

## **1-Paragraph Summary of each of the September Transformation Workgroups**

### **9/22/11 Medicaid/Medicare Integration Work Group Meeting**

The Medicaid/Medicare Integration Work Group members focused on metrics as they pertain to individuals that are dually eligible. Kay Metzger from Lane County AAA presented an orientation to the metrics by talking about the ADL (Activities of Daily Living) assessments that are currently being used by state and AAA case managers. Breakout groups focused on which domains of accountability are particularly relevant for individuals who are dually eligible; and how to best use metrics to hold systems accountable for transforming care and services to this population. The groups emphasized the importance of person-driven systems that include engagement, empowerment and personal accountability; measurements should have identified benchmarks or baselines; and metrics should reflect coordination between providers and CCOs across the spectrum of services, including long-term care. Workgroup members emphasized the significance of recognizing the diversity within the group of people who are dually eligible.

Next Meeting: Wednesday, Oct. 19

Location: Cherry Tree Training Center, Salem, OR

### **9/26/11 Outcomes, Quality, and Efficiency Work Group Meeting**

At their meeting on September 26<sup>th</sup>, members of the Outcomes, Quality, and Efficiency Metrics workgroup considered potential CCO performance measures in five topic areas: equity; coordination and integration; member (or patient) experience; access; and efficiency. Three workgroup members—Myliia Christensen (QCorp), Megan Haase (Mosaic Medical) and Vanetta Abdellatif—gave presentations about the using performance measures to help drive transformation. Workgroup members expressed support for establishing three kinds of CCO accountability metrics: uniform measures across all CCOs; CCO-specific measures; and test or developmental measures. They also stressed the importance of a robust HIT and EMR infrastructure for outcomes measurement. A subset of members voiced a preference for using outcome measures whenever possible, on the grounds that process measures would restrict innovation and limit CCO accountability.

Next Meeting: Monday, Oct. 17

Location: Clackamas Community College/Wilsonville Training Center, Wilsonville, Oregon

## **CCO Criteria Work Group**

### **September 21, 2011 Meeting Summary**

#### **Discussion Topics**

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Oregon Health Policy Board member Eric Parsons gave a summary of the August meeting, including feedback from the Board and the public on the August discussions, and described the products that the Board will deliver to the Legislature in February. Co-Chairs Mike Bonetto and Bruce Goldberg framed the issue to be discussed (health equity, and CCO governance and community engagement) in terms of Health Systems Transformation policy objectives and the guidance in HB 3650. The group then divided into four discussion groups to consider the following discussion questions:

#### **Health Equity**

Health equity and reducing health disparities have been identified as a topic critical to the development of CCO criteria. Assume that the CCO criteria will require a solid approach to health equity and reducing health disparities, and that this approach will also be reflected in the CCO Business Plan.

1. How should we judge the response to that requirement?
2. What would you want to see as evidence that the potential CCO will/can address health disparities?
3. How should this be addressed in performance standards?

#### **Governance and Community Engagement**

1. What are the essential (given in the bill as requirements) and desired components of governance and community engagement that we believe will lead to success of CCOs in performing effectively for the communities they serve?
2. How can OHA evaluate the effectiveness of community engagement and CCO governance? In regions where there are more than one CCO, how should CCOs be compared in terms of effectiveness of community engagement and CCO governance?

#### **Key Points for the Oregon Health Policy Board**

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##### **Health Equity**

- Health disparities and resources for improving health equity need to be assessed on an ongoing basis, beginning with partnerships formed in the planning stages of the CCO certification process.
- Existing data sources (e.g., CAHPS, ER data, and county data) may be used as a starting point to assess health disparities, but the Medicaid and dually eligible populations may

not mirror total population data and CCO applicants should be required to develop and present their own assessment of their service area.

- Health disparities should be identified and addressed whether they are associated with race, ethnicity, age, disability status, mental health and addictions, gender and sexual orientation, or other factors. Race and ethnicity may indicate increased health disparities within some categories such as age and disability status.
- Health equity metrics should address both health outcomes and cost impacts.
- CCO governance and community engagement will be key elements in any successful approach to addressing health equity issues and reducing health disparities.
- CCOs need concrete goals and clearly defined working partnerships to address disparities, including social and support services. Periodic analysis (qualitative and quantitative) will be needed in evaluating effectiveness.
- Over time, CCOs should make substantial progress in addressing disparities relating to the social determinants of health.
- There should be a collaborative for identification and replication of best practices in addressing health equity issues and reducing health disparities.

### **Governance and Community Engagement**

- Safeguards are needed to ensure community values do not infringe upon rights to health care.
- Governance structures must be transparent and accountable, including clear delineation of holding companies and other affiliated organizations.
- The CCO certification process should make clear preferred or required corporate structures regarding such characteristics as for-profit/not-for-profit status, state of incorporation, and scope of operations (Oregon only, multi-state, national).
- The CCO governing board must make clear the fiduciary responsibilities of board members, including those not sharing in the financial risk.
- Community advisory councils must have teeth, with assurances that recommendations to the CCO governing board are fully considered and the community advisory committee is informed of actions taken or deferred.
- Governance and key staff of CCOs should reflect the roles and responsibilities typical of successful organizations in health care and health insurance, as well as the policy objectives of health systems transformation (such as health equity).
- A CCO clinical advisory council component should be considered as a means of assuring best clinical practices.
- OHA should consider an Ombudsperson for each CCO to assure effectiveness of the community advisory council and of community engagement in general.

- CCO governance and community engagement should be evaluated in terms of improvements in processes and outcomes.

## **Small Group Discussion**

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### ***Comments on Health Equity***

- **Defining health equity:** The way we define health equity is important. The group acknowledged the need for a broad and flexible definition that takes into account regional variation across the state. The group asked whether the state or CCOs should define health equity, and subsequent comments favored the state providing potential CCOs with information on health equity and a sample needs assessment framework that CCOs then use to develop their own definition of local disparities that need to be addressed, and their proposed approach to reducing disparities. How different CCOs carry this out will be indicative of their level of commitment to improving health equity. Group members pointed to recurring community benefit interviews as a necessary component of understanding local health disparities. Specific examples of areas that group members felt should be considered include: race, ethnicity, language, health literacy, people with disabilities, gender and sexual orientation, access issues in rural areas, and areas with high rates of uninsurance
- **Need minimum standards & flexibility:** CCOs will need to be held accountable for meeting certain minimum requirements in addressing health equity, but should maintain flexibility in the way they address disparities to reflect differences across communities.
- **Existing data sources** (e.g. CAHPS, ER data, claims data) can be a starting point in assessing health equity, but the Medicaid population will not mirror the general population, especially regarding characteristics relating to health disparities.
- **Local health disparities change over time:** Several group members emphasized that community demographics and health needs are always in flux and that needs assessments need to be performed on an ongoing basis. Recurring needs assessment and asset mapping should inform who serves on CCO governance and advisory boards. For example, Salud Medical Center has noticed a recent growth in the Somali community in Woodburn and is exploring ways to improve their access to care.
- **Social and human services should be coordinated with health services in addressing health disparities, and social justice factors should be included** (e.g., education, income, employment status).
- **The diversity of the CCOs providers should reflect the diversity of the communities in the CCO's service area.**

- CCOs can provide mutual support: Learning networks or collaboratives could help CCOs to share successes and lessons learned.
- Infrastructure for tracking outcomes: Many of the outcomes of interest cannot be tracked using existing claims database systems. This will require forethought in to how to track and report outcomes.
- CCO partnerships: CCOs will need to partner with local organizations in order to successfully understand and address health equity issue specific to the community. More specifically, CCOs should clearly specify their commitment to their partners and vice versa. Partnerships can help CCOs overcome a lack of financial resources to improve equity, but care must be taken so that CCOs do not try to offload their responsibility on to other organizations. The state could evaluate such relationships to determine CCOs effectiveness at improving health equity.
- CCOs' experience improving equity: Some group members felt that reviewing potential CCOs records in improving health equity (e.g., addressing transportation issues or language barriers) could be more indicative of their capacity to reduce disparities than would simply reviewing a prospective plan for improving equity.
- Granularity of data collected must be sufficient for racial and ethnic distinctions within broad classifications (e.g., within Asian - Chinese, Korean, Japanese, Vietnamese, Laotian, etc.; within Hispanic - Mexican, Guatemalan, Puerto Rican, etc.).
- CCOs should identify key community leaders who are appropriate representatives and work with those leaders to reach diverse communities with strategies for reducing health disparities.
- Addressing disparities through administrative processes: One member stressed the importance of administrative processes in reducing health disparities and suggested that the ways in which processes and forms (e.g., billing) were laid out could provide a clear indicator of CCOs work to improve health equity.
- CCOs need concrete goals: In their plans for addressing health disparities, CCOs should put forth specific, measurable and substantial but achievable goals for reducing health disparities, and define what investments they will make to reach these goals. Although change will take time, the state can assess CCOs progress against these goals. CCOs should describe both short-term and long-term goals. Because of the difference in the needs of varying groups, CCOs should likely stratify their population when setting goals. In addition, CCOs should be required to prioritize their goals.
- Additional potential evaluative criteria:
  - Staff training on health equity and disparities

- CCO workforce diversity
- CCO governance board and community advisory committee diversity

***Comments on CCO Governance and Community Engagement***

- Community values could conflict with reform: HB 3650 states that CCOs' governance structure includes "[t] the community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community." Several members expressed concerns that some community values may conflict with the intent and policy objectives of health care transformation (e.g., addressing the health needs of immigrant communities or assuring appropriate end of life care services). That state should make its values clear, exercise existing safeguards when appropriate and develop new safeguards to the extent they are lacking. The state's certification process can communicate transformation values.
- Collaboration among community partners will be important in bringing resources together to leverage dollars and services. Asset assessment and mapping should be done for each CCOs service area.
- Governing board representation: some members expressed the importance that essential groups be represented on the governing board, including:
  - Individuals with financial risk for CCO performance
  - Physicians
  - Behavioral health providers
  - Consumers from all communities in the CCO service area
  - County governments
- Examples of other groups identified during the meeting included:
  - Dental health providers
  - Disability service providers
  - Social service providers
  - Long term care providers
  - Primary care providers
  - Hospitals
  - Foster care providers
- Role of corporate/parent company board in CCO governance: Group members discussed different possibilities for CCO governance in terms of its relationship with the governance board of its parent entity. Some members expressed concerns that the board of a parent company may not have well aligned interests with the governing board of a CCO. Some

members expressed an interest in having the state provide guidance or requirements on how CCO governance should be structured. Whatever the governance structure, it must be transparent and held accountable.

- Community advisory council “must have teeth”: Members agreed that the community advisory board must have influence in CCO governance. One mechanism to support this that was suggested was for community advisory boards to rate CCO governing boards on their effectiveness in assuring the health of the community.
- Process for selecting community advisory council members should be transparent and accountable: its success should be measured in terms of the effectiveness of the CAC in representing the needs and preferences of the communities in the CCO’s service area, in the form of policy recommendations and feed-back to the governing board on access and outcomes issues.
- The utilization and effectiveness of community health workers, health systems navigators, and peer wellness counselors should be evaluated in gauging the effectiveness of the Community Advisory Council.
- A clinical council should also be considered composed of providers of care and addressing issues relating to improving access and health outcomes, with significant input on the design and operation of the CCO delivery system.
- Traditional board roles should be required: Group members recommended that CCO boards should be held to commonly accepted organizational governance standards. For example, the CCO should have a chief compliance officer who reports directly to the CCO governing board.

## Global Budget Methodology Work Group September 20, 2011 Meeting Summary

### **Discussion Topic: Risk Sharing between State and CCOs**

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Carolyn Ingram—Senior Vice President at the Center for Health Care Strategies and former New Mexico State Medicaid Director as well as Senior Manager with the Lewin Group—presented examples of innovative Medicaid risk-sharing arrangements and discussed relevant considerations for evaluating them. Examples from other states included:

- Utah’s full-risk capitation arrangement that establishes rates for Accountable Care Organizations (ACOs) for five years; and,
- Minnesota’s shared risk (both upside and downside) arrangements with integrated delivery systems and shared savings (upside only) arrangements with other groups.

Key risk sharing considerations included:

- Incentives for greater efficiency and integration of care
- Fostering budget predictability
- Potential flexibility in setting up risk sharing arrangements
- Addressing administrative complexity

The work group split into three breakout groups to discuss their concerns with regard to financial risk, models that address those concerns, and incentives for promoting care coordination.

### **Key Member Feedback: Focus on Long-Term, Outcomes-Oriented Risk Arrangements**

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The small groups provided the following feedback

- Risk concerns
  - Actuarial models and soundness requirements need to be clearly defined
  - Existing MCOs are currently tapping reserves and may be poorly positioned to invest in transformation and take on additional risk.
  - Enrollment growth associated with the ACA poses an overall budgetary risk.
  - Savings from care coordination may take several years or more to realize.
  - If CCOs face too much risk, not only could members lose access, but entire health systems that are heavily dependent on Medicaid could erode.
- Model features and incentives that address concerns
  - Acknowledge what works with the existing system. Current MCOs have managed full risk and moving to partial risk arrangements may represent a step backwards. There is a need to identify key weaknesses in the current system, such as coordination between mental health and physical health, and to determine if new risk arrangements will address those concerns.
  - Pursue multi-year arrangements (e.g., five years). Investments in transformation will take time to pay off.

- Any risk sharing arrangement needs to promote outcomes in terms of care coordination, health and equity. Higher performing plans should receive more favorable risk arrangements.

Work group members requested more detail on changes that need to be made. They were very interested in understanding what the state believes is working in the current system in order to focus their planning and efforts on high-priority changes that need to be made.

## **Small Group Discussion**

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### **1. Risk Concerns Discussed**

#### Types of Risk – Actuarial, Performance and Transformation; Enrollment Risk from ACA

One breakout group categorized CCO financial risk as follows

- *Actuarial or Medical Risk* – Risk for claims driven by the health status of CCO members. This can be addressed by risk adjustment.
- *Performance Risk* – Risk of not being able to transform delivery systems to successfully provide coordinated care. CCOs should bear this risk, but the state should help to minimize it.
- *Transformation Risk* – The risk of not realizing sufficient savings to cover the budget shortfall even if transformation is successful. The state should acknowledge this risk and share it with CCOs.

Another group pointed out that enrollment risk can put pressure on the overall Medicaid budget. The planned expansion of Medicaid in 2014 will increase enrollment and significantly so in low-income communities. CCOs that serve these communities cannot handle this enrollment risk.

#### CCOs' Resources are Tight but Change is Inevitable

One group mentioned several financial strains on the Medicaid system from the state budget, to MCOs currently tapping reserves, to providers receiving lower rates. While this situation makes it difficult to assemble resources to carry out successful transformation (e.g., setting up robust information systems), but it also makes change inevitable.

#### Consumers Could Lose Access and Systems Could Erode if CCOs Face Too Much Risk

If CCOs become insolvent or reduce reimbursement to an unsustainable level not only could CCOs collapse, but also consumers could lose access to timely health care services and local health systems could split in terms providers who serve Medicaid members and those who do not or fall apart altogether. The latter is a more significant issue in communities where Medicaid coverage is prevalent.

### **2. Models that Address Concerns and Incentivize Transformation**

#### Building Off of Existing MCO Full-Risk Arrangements

Almost all of the current plans have full-risk arrangements, and we should build off of this capacity rather than curtail it.

#### Long-Term Risk Sharing Arrangements Are Preferable

Several groups emphasized that risk sharing arrangements with the state should have long time horizons. There was significant interest in the five-year contracts referenced in Carolyn Ingram's presentation. Successful transformation will take time and reaping the financial benefits of coordinated care will take even longer. Thus, risk sharing arrangements between the state and CCOs should allow enough time to invest in change and subsequently realize the return on this investment. Otherwise, CCOs will face lessened incentives to carry out transformation.

#### Focus on Outcomes

Each group made clear that any risk sharing arrangement between the state and CCOs must be structured to incentivize clinical integration, access, health outcomes and health equity. One group suggested that the initial focus should be on successful clinical integration and shift over time to health outcomes. This group also expressed that the state should take on a greater share of risk in proportion with CCOs' demonstrated successes in clinical integration (including physician driven quality improvement initiatives and provider shared risk/shared savings agreements). This would require the state to lay out more prescriptive measures and accountability mechanisms while still allowing CCOs to innovate.

Another group discussed the importance of financial arrangements pushing the integration of services as broadly as possible to support innovation and the "really hard work" of care coordination. Accountability systems will need to provide timely feedback and allow for adjustments over time.

#### Rate Setting and Risk Sharing Decisions Should Be Transparent and Involve CCOs

One group requested transparency with regards to actuarial modeling and soundness requirements as well as what changes are anticipated from transition. CCOs will need this in order to determine their ability to take on risk. Each group mentioned actuarial modeling and soundness in various contexts. Some wanted more information on its definition and the actuarial modeling that determines soundness. Others expressed concern that actuarial soundness's role in does more to promote insurers' interests but not the overall goals of the health care system. Finally, one group felt that CCOs need to be involved in the rate setting and risk sharing to make sure that they have bought in to the transformation process.

#### Removing Administrative Obstacles

Several groups stressed that removing administrative obstacles will be crucial to successful risk sharing. CCOs need flexibility to invest in effective services that are not currently covered without the state or federal government withdrawing risk sharing. The risk sharing arrangement itself should not create undue administrative burdens.

#### Spreading Risk

Although the focus of the meeting was risk sharing between the state and CCOs, several groups emphasized that upside and downside risk needed to be spread throughout the system—including the state, CCOs, providers and patients—in order to align incentives. However, several groups also noted that MCOs currently manage full risk through a capitation model, suggesting that we could build off of this and that moving to a partial risk arrangement with the state could represent a step back.

#### Flexible Risk Arrangements to Address Community Differences and Change Over Time

Several groups mentioned that there may be a need for different models of risk sharing arrangements in different communities. Different communities have different underlying needs and have experienced different degrees of success in achieving good health outcomes under the current system. In addition, CCOs capacity to manage risk should increase with experience. As a result, risk arrangements should allow for CCOs exposure to financial risk to change over time.

#### ***Additional thoughts that emerged from workgroup discussions***

- Coordination with social services can improve outcomes: One group emphasized the need to improve the connection between the health system and social services, asking if CCOs should bear risk for social services as well.
- The state could provide technical assistance to implement provider payment reform.

## **Outcomes, Quality, & Efficiency Metrics Work Group**

### **September 26, 2011 Meeting Summary**

#### **Discussion Topics**

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Oregon Health Policy Board member Dr. Carlos Crespo gave a re-cap of the August meeting, summarized feedback from the Board and the public on the August discussions, and described the products that the Health Policy Board will deliver to the Legislature in February. Workgroup members also heard three brief presentations on the topic of using performance measures to help drive transformation. The group subsequently was divided into three smaller discussion groups to consider potential CCO performance measures in five topic areas: equity; coordination and integration; member (or patient) experience; access; and efficiency. Members were asked to address three questions in relation to the example measures listed (*see meeting materials*):

- Which indicators are “must-haves” for CCO accountability?
- Which indicators are not good candidates for CCO performance measures?
- What other indicators should be considered?

#### **Key Points for the Oregon Health Policy Board**

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- Members expressed support for the three ‘buckets’ of measures outlined by Dr. Hofmann and the Health Policy Board: uniform measures across all CCOs; CCO-specific measures; and test or developmental measures.
- At both the August meeting and this one, workgroup members expressed an interest in keeping all types of measures—structure, process, and outcome—on the table, as long as the measure type was appropriate to the topic. However, at the September meeting, several people expressed a strong preference for using outcome measures whenever possible, on the grounds that process measures would restrict innovation and limit CCO accountability (the more the state dictates the process, the more the state itself becomes accountable for the result). One suggestion was to use process measures when there are key evidence-based practices we know we want to promote and when outcomes are difficult to measure or have a long time-frame for measurement.
- Members stressed the importance of EMR and HIT capacity for both CCO operations and the ability to capture the kind of outcomes data that the group is interested in for performance measures. However, some members cautioned that claims data will still be valuable even when EMRs are widely used, and others reminded the group that neither data source will capture the health of CCO members who aren’t using services.
- In some small workgroups, questions arose about the scope of CCO accountability. There remains some confusion about the extent to which CCOs should be responsible for the

health of people who are not CCO members, but who reside in the communities that a CCO serves.

- At various points, members noted that transformation would also be required within the state to support delivery system transformation.

## **Presentations**

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Workgroup members heard three brief presentations on the topic of using performance measures to help drive transformation.

- Mylia Christensen—workgroup member and Executive Director of the Oregon Healthcare Quality Corporation—gave an overview of the state of quality measurement around the transformation-related topics on the meeting agenda. She noted that measurement of these topics was a rapidly developing field and that there is no performance data from entities comparable to CCOs from which to develop benchmarks. As a consequence, the principles and criteria discussed at the last meeting become very important. She urged the group to focus on things CCOs can change, choose valid measures that harmonize with other initiatives where possible, and to think carefully about granularity and level of measurement.
- Megan Haase—CEO of Mosaic Medical in Bend—described a care coordination pilot for high utilizers and distributed a list of the quality measures used in association with the shared savings component of that pilot (*see meeting materials*). She noted that some of the initially selected metrics did not work well and needed to be replaced for year 2 of the pilot and that they were working to get claims data in a more timely manner while waiting for EMR capacity to mature.
- Vanetta Abdellatif—Director of Integrated Clinical Services at the Multnomah County Health Department—provided an overview of a medical home pilot project at Multnomah County (*see meeting materials*). She noted some impressive results in improved clinical outcomes (e.g. diabetes bundle, severe depression), continuity rates, and patient-centeredness. She urged the group not to let perfection be the enemy of good enough.

## **Small Group Discussion**

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Note: Comments that pertain specifically to individual performance measures listed in the meeting discussion document can be found in a table following this section.

### *General Comments*

- Several members commented that behavioral health issues (both mental health and addictions) were not visible enough in the list of measures proposed for discussion.
- Similarly, members were interested in seeing more potential indicators of overall health outcomes and around CCOs' level of community engagement. With respect to community

engagement, one breakout group suggested monitoring CCOs' success in reaching out to and engaging all of its members, or awarding 'bonus points' for CCOs that use innovative methods (such as use of Community Health Workers) for outreach, leading to better patient engagement.

- One member urged the group to think about performance measures that would be meaningful to individuals making a choice between CCOs.
- Another suggested that OHA should determine the cost of measurement and reporting for the final set of CCO accountability measures selected and critically examine the value.
- Finally, one member commented that performance measures will not be a sufficient to judge CCO performance and transformation; formative evaluations (audits) will also be needed.

#### *Comments on potential measures of Equity*

- There was some debate about whether equity should be called out as a separate topic for CCO accountability, with its own performance measures, or whether attention to equity should be infused throughout the other topics. The danger in the first approach is that equity concerns become compartmentalized; the danger in the second is that they get lost. The loose consensus in one breakout group was that a combined approach would be best, with some commenting that it might be possible to retire a separate equity set of measures after some period of CCO operation.
- Several members advised OHA to consider factors like disability status, LGBT identification, or presence of a mental illness when monitoring CCO's success in improving health equity, along with race, ethnicity, and primary language.
- One member commented that OHA needs to take more responsibility for improving the quality of race, ethnicity, and primary language data collected at eligibility/enrollment. In another group, members suggested that CCOs ask directly about the language in which members prefer to receive services and information, as a component of addressing health literacy.
- One member suggested that the Office of Multicultural Health should help decide on equity metrics.
- Additional Equity measures suggested include (these are also listed in the table following this section):
  - A structural measure of CCO workforce composition
  - A measure of CCOs' success in reaching out to members who do not utilize services

#### *Comments on potential measures of Care Coordination and Integration*

- Measures under this topic should align with those used for the children's wraparound initiative (HB 2144) and the Governor's Early Learning Council (e.g. Kindergarten Readiness).

- Additional Coordination and Integration measures that were suggested include (these are also listed in the table following this section):
  - Coordination with community-level resources (e.g. percentage of medical teams that have coordination with community teams for community services and supports)
  - Coordination of care at the end of life

*Comments on potential measures of Member (Patient) Experience and Engagement*

- One group commented that member/patient experience may be the single most important aspect of CCO performance to measure.
- However, the same group cautioned that member surveys are expensive to support over time and suggested that consolidated survey efforts and/or standard instruments would be more practical and valuable than multiple levels of survey administration or multiple versions of questionnaires.
- In full group discussion, it was noted that expense of member experience surveys is driven by how much granularity is desired in the results (CCO-wide? Medical group level? Individual clinician?). Another member commented that the data become less actionable as granularity decreases and gave the CAHPS Health Plan survey as an example of a survey that does not generate useable information.
- Measurement of experience should go beyond satisfaction to assess whether members' informational needs are being met and the quality of members' relationships with their providers.
- Some workgroup members saw increasing member activation as key to the CCO concept; others felt that activation would not be a valuable CCO performance measure because activation is only an intermediate step to an ultimate goal (e.g. better patient self-management).
- Additional Patient or Member Experience measures suggested include (these are also listed in the table following this section):
  - Some measure of churn, either from CCO to CCO or from provider/group to provider/group within a CCO

*Comments on potential measures of Access*

- There was some debate about the merits of using patient- or member-reported data vs. objective data on utilization rates or penetration to assess access. Some members consider member reports less valuable because patients sometimes feel that they need more care than they do; others believe that this is an important gauge of patient experience. A balance between the two data types would be best.
- Additional Access measures that were suggested include (these are also listed in the table following this section):

- Utilization of preventive and primary care service utilization specifically
- (Appropriate) emergency department utilization (listed under Efficiency)
- Penetration/take-up of addiction services

*Comments on potential measures of Efficiency and Costs*

- Members commented that risk adjustment would be necessary to compare across CCOs and across providers within CCOs. They suggested that individuals eligible for both Medicare and Medicaid would be a particular challenge for risk adjustment.
- Members stressed the need to measure access and quality of care (according to evidence-based guidelines) alongside efficiency and costs, to guard against unintended consequences or perverse incentives for inadequate care.
- Members made a few suggestions for analytic approaches to efficiency and cost control that may be most appropriately undertaken by CCOs themselves, including:
  - Monitoring spend on “high-risk” groups as a proportion of total costs;
  - Assessing cost drivers within the CCO population and making shifts in services or reimbursement rates accordingly.
- More than one group emphasized the importance of measures that would assess whether the most appropriate and efficient mix of services is being delivered to members (e.g. ED visits vs. office visits, or ED visits for dental, mental health, or substance abuse issues).
- Additional Efficiency or Cost measures that were suggested include (these are also listed in the table following this section):
  - Some measure(s) of cost shift:
    - To services and facilities outside the CCO umbrella and budget (e.g. state hospital)
    - Towards prevention and primary care within the CCO budget (over time, utilization and proportion of spend in these areas should increase)
  - Cost trend over time (e.g. average annual change in per-capita expenditure)
  - Medical Benefit Ratio (MBR or MLR) - Proportion of revenue/global budget spent on medical care and services
  - Some measure of costs or appropriate utilization of care at the end of life (e.g. % members for whom end of life care matches POLST; or % members who die in the hospital; or hospice LOS; or use of palliative care)

For comments on particular measures, please see the table on the following page.

Measure	Data type	Alignment *	COMMENTS
<b>Topic: Equity</b>			
<p>Note: It is assumed that CCOs will be subject to the new OHA &amp; DHS policy regarding collection of race, ethnicity, and primary language data, such that any CCO performance measure could be reported and analyzed by those demographic factors (numbers permitting). For contractual accountability, we are considering focused measures such as the ones below.</p>			
<p><b>Cultural competency</b> - composite score for provider cultural competency from CAHPS supplemental item set</p>	Patient or enrollee survey	AHRQ (CAHPS)	<ul style="list-style-type: none"> <li>· Fold this into patient experience</li> <li>· This item set is relatively untested</li> <li>· Culturally competent care is particularly critical for high needs patients</li> </ul>
<p><b>Diversity training</b> % CCO staff (clinical and administrative) who have received diversity training</p>	Admin data	JCAHO, NQF	<ul style="list-style-type: none"> <li>· This should be a contractual requirement, if used</li> <li>· This does not necessarily differentiate between CCOs in a useful way</li> </ul>
<p><b>Variations in care</b> Variation by race, ethnicity, and primary language on these measures:</p> <p><b>Access</b> - average time from enrollment to first encounter AND nature of first encounter (initial health &amp; risk assessment, other non-urgent, or urgent)</p> <p><b>Chronic disease management</b> - % diabetics with dilated eye exam in last year</p> <p><b>Care coordination</b> - % enrollees discharged from hospital who have a visit with PCP within 30 days</p> <p><b>Provider communication</b> – composite score for quality of provider communication (patient reported data)</p>	<p>Claims / encounter data</p> <p>Claims / encounter data</p> <p>Claims / encounter data</p> <p>Patient or enrollee survey</p>	<p>Unknown</p> <p>Medicare ACOs, Meaningful Use, QCorp</p> <p>Medicare ACOs</p> <p>CAHPS Medicaid adult; CHIPRA, HEDIS</p>	<ul style="list-style-type: none"> <li>· This isn't or needn't only be about equity; it's simply unwarranted variations in care more broadly</li> <li>· Don't specify an arbitrary focus a priori; instead see what variations emerge from the data</li> <li>· Dilated eye exam in particular is not compelling; patient experience, readmissions, and others likely better</li> </ul>

Measure	Data type	Alignment *	COMMENTS
<b>Workforce composition (structural measure)</b>			· Availability of interpretive services also mentioned but perhaps as a contractual requirement
<b>Measure of capacity or success of outreach to enrollee population</b> (could be specifically the portion of members not utilizing care)			
<b>Topic: Coordination &amp; Integration</b>			
<b>Patient-centered medical homes</b> % enrollees assigned to a PCMH	Admin data	OR PCPCH	
<b>Follow-up after hospitalization</b> % enrollees discharged from hospital who have a visit with PCP within 30 days  % enrollees discharged with a primary mental health diagnosis who have a follow-up visit within a) 7 days and b) 30 days	Claims / encounter data  Claims / encounter data	Medicare ACOs  Medicaid adult, CHIPRA, HEDIS	· 30 days is too long (use 7-10 instead, according to member risk) and don't just count follow-up visits to PCP.
<b>Care Transition Measure (CTM-3)</b> 3-item questionnaire measuring quality of patient preparation for transitions (understanding own role; medication reconciliation; incorporation of personal preferences into care plan)	Patient survey – hospital setting	Medicare ACOs	· Prefer to measure outcome (e.g. readmissions)
<b>Medication reconciliation ^</b> % of discharges for patients aged 65+ where medications were reconciled on or within 30 days of discharge.	Claims / encounter data or medical record	Medicare ACOs, HEDIS	· This too should be within 7-10 days, not 30 · Why limit this to 65+ when it is relevant for everyone? · “Reconciliation” is a difficult term to operationalize; call this coordinated medication management plan.

Measure	Data type	Alignment *	COMMENTS
<p><b>Behavioral health integration ^</b></p> <p>% members with a chronic disease diagnosis who received screening for depression and substance abuse in past year</p> <p>% members with a mental health or substance abuse diagnosis who received physical health screening in past year</p>	<p>Claims / encounter data or medical record</p>	<p>Partial: Medicaid adult, Medicare ACOs, OR PCPCH</p>	<ul style="list-style-type: none"> <li>· EVERYONE should receive these screenings but keep this focus for performance measurement as it will help push transformation</li> <li>· One member commented that appropriate follow-up should be part of these measures, as opposed to screening alone</li> </ul>
<p><b>Readmission rates ^</b></p> <p>Plan (CCO) risk-adjusted, all-cause 30-day readmission rate (NCQA/HEDIS measure)</p> <p>Inpatient psychiatric care: 30- and 180- day readmission rates</p>	<p>Claims / encounter data</p> <p>Claims / encounter data</p>	<p>Medicaid adult, HEDIS, Medicare ACOs</p> <p>SAMHSA - National Outcome Measure</p>	<ul style="list-style-type: none"> <li>· Several members emphasized the usefulness of monitoring readmissions as an outcome measure for care coordination and successful transitions of care</li> <li>· Readmissions are also relevant to costs/efficiency</li> </ul>
<p><b>Coordination with child welfare</b></p> <p>% children who receive a mental health assessment within 60 days of being taken in to DHS custody</p>	<p>Claims/ encounter data with child welfare data</p>	<p>Federal regulation; CAF and AMH initiative</p>	<ul style="list-style-type: none"> <li>· Goal is good but this is largely outside CCO sphere of influence – do not use.</li> <li>· Suggestion to measure the number of foster placement disruptions due to mental or behavioral issues instead</li> </ul>
<p><b>Children’s oral health screening</b></p> <p>% of children under 36 months who have received oral health risk assessment (from dental professional or as part of regular well-child visit)</p>	<p>Claims / encounter data</p>	<p>Pending</p>	<ul style="list-style-type: none"> <li>· Wherever possible, don’t just measure screening – it’s the follow-up that is important (e.g. application of fluoride varnish in this case)</li> <li>·</li> </ul>
<p><b>Coordination with Community</b></p> <p>E.g. % of medical teams with that coordinate with community-level resources</p>			<ul style="list-style-type: none"> <li>· Would need encounter for community services and supports</li> </ul>

Measure	Data type	Alignment *	COMMENTS
Care coordination at the end of life			
<b>Topic: Patient Experience and Engagement</b>			
<p><b>Patient experience of care</b></p> <p>From CAHPS Health Plans &amp; Systems survey (adults &amp; children sampled separately, includes items for children with chronic conditions) :</p> <ul style="list-style-type: none"> <li>· Provider communication composite</li> <li>· Customer service composite (treated with courtesy &amp; respect)</li> <li>· Overall rating of primary provider</li> <li>· Overall rating of quality of health care received</li> </ul> <p>From annual survey of mental health service recipients:</p> <ul style="list-style-type: none"> <li>· % reporting that the services they received were appropriate and good quality</li> <li>· % caregivers reporting satisfaction with coordination between mental health provider and other social services (education, law enforcement, etc.)</li> </ul>	Patient or enrollee survey	Medicaid adult; CHIPRA, HEDIS (Medicare ACO reporting includes items from the CAHPS clinician & group survey, not the Health Plan version)	
<p><b>Shared decision-making ^</b></p> <p>% respondents reporting that, when multiple treatment options were available, their provider: a) explained the pros &amp; cons; and b) asked what option would work best for respondent</p>	Patient or enrollee survey	HEDIS (these items are from NCQA's version of CAHPS)	<ul style="list-style-type: none"> <li>· This is part of quality of patient-provider relationship</li> <li>·</li> </ul>

Measure	Data type	Alignment *	COMMENTS
<p><b>Patient Activation Measure (PAM) ^</b> 13-item scale developed by Judy Hibbard; measures knowledge, skills and confidence essential to managing one’s own health and healthcare</p>	Patient or enrollee survey	Unknown	<ul style="list-style-type: none"> <li>· Is this appropriate for CCO-level accountability or action?                             <ul style="list-style-type: none"> <li>· Perhaps this is something CCOs could offer as a tool to providers?</li> <li>· Or phase it in? E.g. initial accountability could be that CCOs assess patient/member activation and longer-term accountability could be to improve member activation over time?</li> </ul> </li> </ul>
<p><b>Member churn</b> From provider to provider within CCO, and across CCOs</p>			<ul style="list-style-type: none"> <li>· May not always be related to member experience; could be convenience or some other factor unrelated to their experience of care</li> </ul>
<b>Topic: ACCESS</b>			
<p><b>Getting needed care ^</b> % enrollees reporting that it was usually or always easy to get appointments with specialists and get the care, tests or treatment they needed (composite from CAHPS Health Plans &amp; Systems)</p>	Patient or enrollee survey	Medicaid adult	
<p><b>Getting care quickly ^</b> % enrollees reporting that it was usually or always easy to get care as soon as they needed (composite from CAHPS Health Plans &amp; Systems)</p>	Patient or enrollee survey	Medicaid adult	
<p><b>Time to care</b> Average time from enrollment to first encounter AND nature of first encounter (initial health &amp; risk assessment, other non-urgent, or urgent)</p>	Claims / encounter data	Unknown	
<p><b>Preventive dental services</b> % enrollees who received a preventive dental service during measurement year (by age)</p>	Claims / encounter data	CHIPRA, OR PCPCH	

Measure	Data type	Alignment *	COMMENTS
<b>Mental health service penetration</b> % enrollees who utilize mental health services	Claims / encounter data	AMH	<ul style="list-style-type: none"> <li>· Worth highlighting given importance of mental health issues but would need to have decent estimate of underlying need first, at CCO level</li> <li>· Call out addictions as well</li> </ul>
<b>Preventive services</b> % enrollees who access primary care and preventive services			
<b>ED utilization</b> Note: This was suggested under Access by one group; it was also listed under Efficiency in the original discussion document)			
<b>Topic: EFFICIENCY and COSTS</b>			
<b>Hospital utilization</b> Admissions per member-month	Claims / encounter data		<ul style="list-style-type: none"> <li>· Prefer to measure ambulatory-care sensitive admissions (e.g. AHRQ measures)</li> </ul>
<b>Average hospital length of stay</b>	Claims / encounter data		
<b>ED utilization</b> ED visits per member-month	Claims / encounter data		<ul style="list-style-type: none"> <li>· Prefer to measure non-emergent ED visits (e.g. using NYU algorithm)</li> </ul>
<b>PMPM costs for:</b> Emergency Department Inpatient Hospital Outpatient Hospital Ambulatory Surgical Center Professional Services Drugs	Claims / encounter data		<ul style="list-style-type: none"> <li>· In one group, members advised not using these as performance measures. They argued that each CCO will have its own contracts, so the information would not be meaningful. Similarly, CCOs could decide to put money towards care not captured in these categories (e.g. alternative medicine).</li> <li>· Another group suggested that mental health and oral</li> </ul>

Measure	Data type	Alignment *	COMMENTS
Durable Medical Equipment Imaging Services Laboratory			health should also be tracked specifically, along with total PMPM as well.
<b>Use of imaging studies for low back pain ^</b> % of members with a primary diagnosis of low back pain who had an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis	Claims / encounter data or medical record	Medicaid adult, Meaningful use, OR PCPCH, HEDIS, QCorp	· One group had some disagreement about the value of this particular measure. There is national and state momentum around reducing inappropriate imaging but some felt that costs of imaging were too varied.
<b>Cesarean rate ^</b> % of women with first, live, singleton birth (not breach) who had cesarean	Medical record or birth certificate	CHIPRA	· Need to consider population risk with respect to this measure. Elective cesareans for full-term, healthy births is a more obviously “negative” measure.
<b>Cost trend measure</b> (e.g. average annual change in per-capita expenditure)			
<b>Medical benefit ratio ( or medical loss)</b> Proportion of premium revenue (or global budget) spent on medical care and services			
<b>End of life measure (re: cost)</b> Some measure(s) of appropriate resource use at the end of life			<ul style="list-style-type: none"> <li>· % members for whom end of life care matches POLST</li> <li>· % members who die in the hospital</li> <li>· Hospice LOS</li> <li>· Use of palliative care</li> </ul>
<b>Some measure of cost shift to services and facilities not under the CCO umbrella</b>			

## **Medicare – Medicaid Integration of Care and Services Work Group September 22, 2011 Meeting Summary**

### **Discussion Topics**

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#### **Letter of Intent to CMS**

Co-Chair Judy Mohr Peterson presented the group with a draft letter of intent to pursue a memorandum of understanding with the Centers for Medicare and Medicaid Services (CMS) in response to a State Medicaid Directors letter. The purpose of this letter was to inform CMS that Oregon is proposing to adopt a statewide capitated model for integrating and coordinating health care delivery system to better serve individuals who are dually eligible for Medicare and Medicaid. Discussion included questions about CMS financial participation in a new model, and around the vision for shared financial responsibility between Coordinated Care Organizations (CCOs), the state, and providers of long term care supports and services.

#### **Orientation to ADLs, Metrics and Our Current System**

Kay Metzger of Lane County Area on Aging Agency (AAA) and Bob Weir, Field Operations Manager for the Northwest Senior and Disability Services provided the group with an orientation to long-term care case management focused on metrics. They handed out the Activity of Daily Living (ADL) Assessment Tool, Service Assessment Basics, and an example of a “Day in the Life” of a case manager, demonstrating the complexity and coordination/integration currently experienced by Seniors and People with Disabilities (SPD) / AAA case managers.

#### **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:

- What domains of accountability are particularly relevant for individuals who are dually eligible?
- How do we use metrics to hold systems accountable for transforming care and services to individuals who are dually eligible?

#### **Key Points for Oregon Health Policy Board – Proposed CCO Accountability Metrics and Domains**

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The following were the key points that the workgroup members wished to present to the Health Policy Board.

Accountability domains should reflect the following:

- Person driven systems should include empowerment, engagement as well as individual accountability
- Long term care system performance
- Lowering cost through more appropriate utilization
- Improving quality of care
- Expanding use of non-traditional work force

Accountability metrics should reflect the following:

- Clear benchmarks or baselines across CCOs
- Understanding within metrics development that the population of individuals receiving both Medicare and Medicaid is diverse and have unique needs
- Metrics should reflect coordination between providers and CCOs
- Mental health measures
- Measuring patient engagement as well as involvement of “natural advocates”
- Qualitative measures should be integrated
- Measuring all performance, including poor performance

### **Small Group Discussion**

#### ***What domains of accountability are particularly relevant for individuals who are dually eligible?***

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Members reflected on the Proposed Principles and Domains of Accountability document that was presented to the Health Policy Board from the Outcomes, Quality, and Efficiency Metrics workgroup.

The breakout groups supported the following as important domains from the Domains of Accountability document to include when considering individuals who are dually eligible:

- Care coordination
- Access
- Cost containment, including through more appropriate utilization
- Patient activation

The suggested additional stand-alone domains to include were:

- Workforce capacity and development, including the non-traditional workforce
- Patient centeredness or patient driven care
- Patient empowerment and engagement
- Quality of care
- Safety/avoiding harm
- Patient responsibility/accountability
- Long term care system performance

Groups recommended that the coordination of care should include coordination between the CCO and the Long Term Services and Supports system; as well as coordination of care between providers within the CCO.

All of the breakout groups endorsed need for a core set of system performance and transformation domains with associated benchmarks to

- Ensure comparability of CCOs
- Track performance
- Conduct research and identify trends over time

Other discussion points included:

The proposed domains may not necessarily reflect the needs of key sub-populations or populations of focus, such as individuals with severe mental illness or individuals with dementia.

Additionally, some workgroup members felt that organizing system performance by service type/provider could have the potential for reinforcing silos rather than breaking them down. For example, in an integrated delivery setting, measuring mental health care separately from prevention or outpatient care would not be as relevant as measuring the effect of care on the whole person.

The prevention domain should include the concept of maintaining highest level of function.

***How do we use metrics to hold systems accountable for transforming care and services to individuals who are dually eligible?***

Members reflected on the handout outlining four proposed areas for metrics, including: Healthy Days, Improvement in ADLs, End of Life Care, and Innovation measurements.

Members generally endorsed the proposed metric provided. Metrics that were associated with broader health outcomes, (e.g. healthy days measure or number of days spent in home or home like environment) were thought to be more transformative, as good scores on these metrics would require that a range of medical, social and care coordination activities would have had to happen.

Metrics related to patient experience and involvement:

- Patient-centeredness, although not necessarily easy to measure, would be important
- Patient engagement including involvement of “natural advocates”
- Metrics that track the health of family or caregivers (or their level of strain) were thought by some to be as important as metrics associated with beneficiary outcomes
- Social engagement of beneficiaries (e.g. degree of isolation or objective measure of social network) beyond the medical services network
- Social determinants of health, such as profound isolation, are associated with poorer overall health and poorer responses to treatment; need to include in metrics but challenging to measure
- Patient experience or care or patient satisfaction data might be collected by trained peer specialists, or health system navigators

Metrics related to care:

- Early intervention and prevention are important to prioritize and align system incentives to emphasize
- Mental health measures
- Prevention should include maintaining activities of daily living

Metrics related to functionality:

- Measures of functionality should reflect the improvements possible in the beneficiary. For example, some beneficiaries will demonstrate improvement in ADLs and self sufficiency functioning while some beneficiaries will demonstrate maintenance or “highest level of functioning possible”
- Need broader measures of functionality beyond ADLs – SAMHSA’s self-sufficiency matrix was suggested as a resource/model

Additional comments on holding CCOs accountable through metrics:

- Need to establish ahead of time, clear benchmarks or baselines across CCOs
- Understanding within metrics development that the population of individuals receiving both Medicare and Medicaid is diverse and have unique needs
- Metrics should reflect coordination between providers and CCOs
- Qualitative measures should be integrated
- Measuring all performance, including poor performance