

OHPB Delivery System Transformation Work Groups' September Meetings and Public Feedback

September, 2011

CCO Criteria: Outcome of September work group meeting

Question: How best to assure a CCO is addressing health equity and reducing health disparities?

Key Points for the Oregon Health Policy Board:

- 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.
- Definition of disparity and equity should race, ethnicity, age, disability status, mental health and addictions, gender and sexual orientation, or other factors.
- 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.

CCO Criteria: Outcome of September work group meeting

Question: What are the essential and desired components of Governance and Community Engagement that will lead to success of the CCOs?

Key Points for the Oregon Health Policy Board:

- Governance structures must be transparent and accountable.
- 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.
- Governance and structure of CCOs should look like private industry, but also have capacity to meet social goals (e.g., health equity).

CCO Criteria: Outcome of September work group meeting

Question: What are the essential and desired components of Governance and Community Engagement that will lead to success of the CCOs?

Key Points for the Oregon Health Policy Board:

- Community advisory councils must have “teeth”, with assurances that:
 - Recommendations to CCO governing board are fully considered
 - Councils are informed of actions taken or deferred by the CCO
- A CCO clinical advisory council 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.

Public comments

CCO Health Equity:

- Data collection on income, race/ethnicity of staff and of members. Should reflect community.
- Transparent governance relationship with local public health authority
- Clearly established policy of engagement and involvement of under-represented groups in decision making
- Cultural competence of staff
- Use of community health workers
- Look at spend on primary care, which is most effective care to reduce health disparities

CCO Governance and Community Engagement

- Should systematically poll community
- Community advisory council
- Governance structure should reflect community at large
- Survey members, providers and community partners about effectiveness and governance

Global Budget Methodology: Outcome of September work group meeting

Question: What are the concerns about financial risk with the CCOs; what are the models that address those concerns, and what are the incentives for promoting care coordination?

Key Points for the Oregon Health Policy Board:

Risk Concerns:

- Existing MCOs are tapping reserves and may be poorly positioned to invest in transformation and take on additional risk.
- Enrollment growth associated with ACA.
- Will new risk arrangements address key weaknesses in the current system, such as coordination between mental and physical health?
- Should examine multi-year arrangements, as investments in transformation will take time to pay off.
- If state budget predictability is one of the goals, risk sharing arrangements may create some uncertainty.

Global Budget Methodology: Outcome of September work group meeting

Must be aware of the possibility of systems eroding and consumers losing access to timely care if the CCOs face too much risk.

One break out group categorized types of 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.

Other comments:

- Rate setting and risk sharing decisions should be transparent AND involve CCOs.
- Might be wise to consider a risk sharing arrangement across the system that would include the state, CCOs, providers and patients.
- Flexibility in risk sharing across different communities and eras.

Public Comments

- Concern that private providers will “cherry pick” and leave real liability to public entities
- Should include incentives to work across settings to improve care. Change payment model: carve out primary care and pay a pmpm; pay a cap to hospitals for ER to encourage more triage
- Concern that transformation savings will not trickle down to investing in primary care; patient-centered primary care home model will require investment
- State should determine a target amount CCOs should spend on primary care and change the amount based on outcomes research.
- High-end cost service providers should have higher risk for outcomes.

Outcomes, Quality and Efficiency Metrics: Outcome of September work group meeting

Questions:

- 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:

- Members supported:
 - Core set of uniform measures across all CCOs;
 - CCO-specific measures; and.
 - Test or developmental measures.
- Several members expressed a preference for outcome measures over process measures.
- EMR and HIT capacity for CCOs will be essential for capturing metrics.

Outcomes, Quality and Efficiency Metrics: Outcome of September work group meeting

- More emphasis is needed on behavioral health issues.
- Some members wished to see more metrics around a CCO's level of community engagement and outreach to members.
- Measures should be useful to an individual *choosing* between CCOs.
- Performance audits may still be needed in addition to metrics.
- Debate on how to measure equity:
 - Should equity measures have their own performance measures or should they be infused throughout the other topics?
 - Should disability status, LGBT identification, or presence of mental illness be considered when measuring equity? (In addition to race, ethnicity, and language.)
 - Consider a measure of CCO workforce composition.

Public Comment

- Performance measures should focus on patient-based outcomes and should reflect long-term benefits to the patient
- Concern that proposed measures are still too process oriented rather than outcomes oriented
- Does the metric help lead the CCO to deliver medical care that the patients need and desire?
- Cultural competency, behavioral health integration, % of members with a chronic disease who received screening for depression and substance abuse, % of members who received a mental health or substance abuse diagnosis who received a physical health screening, % of members reporting that it was usually or always easy to get appointments with specialists and to get the care or tests they needed
- Shared decision-making, patient activation, behavioral health integration
- % spent on primary care, % of ED visits/hospitalization with verbal or other direct communication with PCP, readmissions

Medicare-Medicaid Integration of Care and Services: Outcome of September work group meeting

Question: What domains of accountability are particularly relevant for individuals who are dually eligible?

Key points for the Oregon Health Policy Board:

Members emphasized:

- Care coordination (including coordination between CCOs and long-term care services and support systems)
- Access
- Cost containment
- Patient activation
- Person-centeredness
- Care transitions

Each breakout group endorsed a need to ensure comparability of care across CCOs, to track performance, and to conduct research to identify trends.

Medicare-Medicaid Integration of Care and Services: Outcome of September work group meeting

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

Key points for the Oregon Health Policy Board:

Members emphasized:

- Understanding within metrics development that the population of individuals receiving both Medicare and Medicaid is diverse and has unique needs
- Metrics discussed included patient-centeredness, patient engagement, social engagement of beneficiaries, prevention (including activities of daily living) and mental health
- There was also discussion about the need to establish clear benchmarks or baselines ahead of time and across all CCOs

Public Comment

- More important domains are: transformative potential, consistency with existing state and national quality measures with room for innovation, attainability (small wins lead to bigger changes)
- Outpatient physical, adult mental health, inpatient physical, end-of-life care, care coordination and integration, patient experience and activation. Access.
- Consumer education.
- Timely access to care. Access to non-medical supports (e.g., navigation, care management, housing, jobs, etc). Denials. Appeals. Health outcomes. People served in the least intensive environment. Health care dollars spent on care vs. profits and admin. Number of providers available for patients and choice.
- Child and adult mental health, outpatient physical, prevention, and end-of-life care
- Adult physical health and mental health—both inpatient and outpatient. Care coordination and integration. Access.

Next Work Group Meetings

- Global Budget Work Group
Monday, October 17th, 6 to 9 pm, Keizer
Topic: Risk sharing arrangements
- Outcomes, Quality and Efficiency Work Group
Monday, October 17th, 9 am to 12 noon, Wilsonville
Topic: Accountability measures for primary, acute, behavioral and oral health care
- CCO Criteria Work Group
Tuesday, October 18th, 6 to 9 pm, Keizer
Topic: Financial solvency and models from other states
- Medicare-Medicaid Integration of Care and Services Work Group
Wednesday, October 19th, 6 to 9 pm, Keizer
Topic: CCO criteria, care coordination and transitions of care

For meeting agendas and details, go to www.health.oregon.gov

Oregon Health Policy Board Products

OHPB will deliver the following products to the Legislature in February 2012:

- Draft legislative language for implementation of Coordinated Care Organizations (CCOs)
- A business plan for CCO implementation
- Medical liability/cost containment strategies
- Standards for specified health care workers: community health workers, peer wellness specialists, personal health navigators