

THE TRI-COUNTY MEDICAID COLLABORATIVE – A BRIEF HISTORY

Thank you for this opportunity to provide the Oregon Health Policy Board with an update about the Tri-County Medicaid Collaborative.

Today I will be providing you will a brief history of the collaborative, our vision around how we believe care can be transformed in our community to allow for better health, and the challenges that lie ahead and finally, how the OHPB can assist us in these efforts.

In early December, representatives from 6 organizations (CareOregon, OHSU, Legacy, Providence, Kaiser, and the Counties) came together to discuss how best to continue the Medicaid care transformation work that occurred within the OHLC over the past six months. The result of that meeting was the formalization and continuation of a community-wide partnership that is truly unique across the nation and presents this community with an opportunity to improve and transform care for an underserved portion of our population.

The goal of the collaborative is to create a new community organization to ensure cost-effective quality care for those to whom the public shares a responsibility. The organizational and financial structure being established will ensure that both risk and responsibility is borne equitably and that providers are incentivized to produce better care with improved population health and utilization outcomes.

The vision of the collaborative is to create an integrated community delivery system that will achieve better community health for the Medicaid and high-risk uninsured population in the

Tri-County community in which all stakeholders invest by committing resources and/or dollars.

The collaborative has several guiding principles including the following:

- A collective caregiver led initiative to include all those who touch patients
- Optimal system design
- Maximize resources available for care
- Accept global financing methodology
- Design care for population needs
 - Person center primary care home model
 - Integration of physical health, behavioral health, oral health, and social services
 - Align and coordinate specialty care
 - Focus on prevention
- Play or pay (deploy capacity or other resources to meet the need or offset the costs of those who do)
- Transitions of care across the continuum
- End-user/consumer oriented system

The Tri-County Medicaid Collaborative is led by an Executive Steering Committee which now represents nine major healthcare stakeholders including CareOregon, OHSU, Legacy, Providence, Kaiser, Multnomah County, Washington County, Clackamas County, and the FQHCs. The Collaborative hopes to include additional members including FamilyCare, Portland Adventist Health and Tuality Health and will continue to seek input from other stakeholders in the community.

In order to support the work of the Executive Committee, key workgroups have been established in order to provide insight,

guidance, and structure to the collaborative including a Model of Care team, a Revenue Development and Distribution team, a Communications team (including a larger stakeholder group), and a Start Up Development team focused on securing federal CMMI grant funding for the initiative. All participating organizations have dedicated significant resources and time to ensure that this effort succeeds.

Let me give you a sense as to the progress that has been made and the level of collaboration that has occurred over the past four weeks.

We have an executive steering committee and five fully functioning workgroups meeting at least weekly; all with a common vision and principles guiding their work. In addition, we are in the final stages of preparing the CMMI grant mentioned above, designed to specifically reduce costs for high acuity Medicaid patients that will serve as the building blocks upon which the metro-region's CCO can be built.

In the few short weeks since its inception, the TCMC has been able to pull together resources from diverse and historically competitive organizations to build a community wide effort that is well on its way to submitting a \$30 million grant proposal creating the foundation for transforming care in the metro-region.

It is important to remember that this group is only several weeks old and there are significant challenges ahead – a complex and political legislative process, the need to move quickly yet include numerous stakeholders, tough budget/financing decisions, no roadmap to follow, and many more. Despite the challenges, doing nothing is not an option and this group is committed to transforming the healthcare system in the metro-region to better

serve our community. With that in mind, let me turn the conversation to our vision for a transformed delivery system.

TRANSFORMING OUR MODEL OF CARE DELIVERY

The Tri County Medicaid Collaborative has brought all components of the health care delivery system to the table to design an “integrated delivery system” for Medicaid and high risk uninsured members across the region. These include the major health systems and hospitals, primary care, specialty care, behavioral health, dental health and health plans.

Most of us have been working together for years on multiple projects to improve care for Medicaid and uninsured individuals in our community. However, this is the first time we have all worked together in a coordinated way with one unifying goal, which has been an amazing experience and one that is truly unique and groundbreaking as well as challenging.

As you know, many local primary care organizations have been working for years on transforming their practices into “primary care homes.” The model of care we envision builds on the primary care home team, adding community outreach workers to go into the community and into the homes of those individuals who appear to be struggling with overwhelming medical, social and personal challenges. It is our belief that these outreach workers will help patients avoid unnecessary ED visits and hospitalizations by being a first line of information and coordination for patients as well as a connection with providers. Simply stated patients need help navigating the array of complex medical and social services to achieve the best health outcomes.

Our plan is to build on the primary care home team by connecting the various entities of health care delivery; for example, standardizing the way that patients are discharged from hospital. Prior to discharge we can identify those who really don't have what they need to stay out of hospital and make sure the hospital team puts in place a post-discharge plan that is coordinated with appropriate non-hospital care entities to avoid unnecessary hospital readmissions. Part of that plan is to provide the primary care practice and care manager with a discharge summary and a list of critical action items the patient requires to remain at home and a mechanism to follow up on the patient's recovery, compliance with medications, follow-up visits, etc.

The idea is to develop a standard transition hand-off not just in one hospital and one clinic, but to develop a standard of coordination and information exchange that all clinics and hospitals can adopt. Our hope is that this standard will ultimately be used for all patients across our community.

In addition to physical health, the collaborative will also focus on behavioral health, oral health, and social services so that a system is designed and focused on the complete care needs of the individual. We can build a regional collaborative system so these efforts are coordinated to learn the best way to do this new outreach work. Our intent is to identify individuals who need help early and give them the help they need.

The ultimate vision is to increase the quality of health care delivered, to improve overall health outcomes, and to reduce the cost of health care. The Collaborative participants are committed to exploring how their collective efforts may evolve to become a Coordinated Care Organization for this region.

THE CHALLENGES AHEAD AND HOW THE OHPB CAN HELP

Given it will take the next few months for the Collaborative to organize and develop. We want to offer four concepts for consideration by the Oregon Health Policy Board. We offer these concepts to help ensure that important options exist for the Collaborative going forward after the Legislative Session concludes allowing the Collaborative to develop in the best way to serve the Tri-county region.

The four concepts we would like to offer for your consideration are in the areas of (1) Information Sharing, (2) Fast Track, (3) Governance, and (4) Finance.

Information Sharing

The rules regarding sharing of clinical information for patient care between healthcare providers should not be more restrictive than the federal HIPAA requirements. In order to make the CCO function as designed and truly coordinate and integrate the care for the patients, we need to remove unnecessary barriers for information sharing. The integration of behavioral health (including mental and chemical dependency care) is currently prohibited without special release of information approvals. In order to facilitate the sharing of this crucial information across healthcare settings to assist in care integration, we'd like to request a waiver from the Federal government to allow this information to be shared more easily when appropriate.

The role of public health in the work of the CCO is crucial in both developing the community needs assessment and ongoing work on the health improvement plans. In light of this, we feel that

aggregate data sharing should be allowed between the CCO and public health to facilitate that work.

Fast Track

As proposed legislation is considered for the 2012 Legislative Session, the Tri-County Medicaid Collaborative asks that the Oregon Health Policy Board in its recommendations, and the Legislature in its deliberations, consider proposals that support the integrity of the Collaborative's cohesive process. The Collaborative supports legislation that promotes cooperation, flexibility and ingenuity.

Specifically, the Collaboration would like to ensure that legislation aimed at "fast tracking" CCO determination does not inadvertently create incentives for MCOs participating in the Collaborative to pursue CCO determination alone, and that it allows sufficient flexibility for organizations to be provider-led.

Governance

As we work to establish, organize and develop the model of care for the Tri-County Medicaid Collaborative, we will continue to explore the most appropriate governance structure that in accordance with HB 3650 will: "Each coordinated care organization has a governance structure that includes: (A) A majority interest consisting of the persons that share in the financial risk of the organization; (B) The major components of the health care delivery system; and (C) The community at large, to ensure that the organization's decision-making is consistent with the values of the members and the community." (HB 3650 Section 4(1)(o))

In order to ensure that governance options remain available to us as we continue our work after the February Legislative session, we would ask the Oregon Health Policy Board to consider our proposal and allow flexibility in the type of governance of a CCO. Specifically, we would ask that a coordinated care organization (CCO) organization, be allowed to establish itself as (i) as a private non-profit organization, (ii) as a public corporation, or (iii) through contractual relationships such as a joint venture.

Finance

As established in the "Guiding Principles" of The Collaborative – maximizing resources available for care is a priority. The Tri-County Medicaid Collaborative urges the Oregon Health Policy Board to strongly recommend to the Legislature for its consideration - the financing and revenue structures established for the CCO's should maximize federal funds that could be available for the care of all Oregonians.

The proposed \$239 million reduction to the OHP in the second year of this biennium will result in an additional loss of over \$400 million in Federal match funding. It cannot be overlooked that the loss of over \$600 million to the Medicaid system will have a negative impact now and into the future. This decrease in funding may also trigger a decrease in the baseline for Federal match funding in 2014 and beyond. 36% of Oregon's Medicaid population resides in the Tri-County area; in addition there are thousands more uninsured. The Collaborative stands ready to help pursue all options that will maximize resources available for these Oregonians.

IN CLOSING

Again, thank you for this opportunity to provide the OHPB with an overview of the Tri-County Medicaid Collaborative. We appreciate your insights and support as we continue down the transformation path towards better quality of care, improved population health, and reduced costs for our healthcare system. We would be happy to take any questions from the OHPB. Thank you.