

## 2014 Coordinated Care Model Alignment Workgroup

November 13, 2014

12:00 p.m. – 2:00 p.m.

Lincoln Building, Room 775

421 SW Oak Street

Portland, Oregon 97204

Public listen-only conference line: 888-363-4734; Participant code: 1050791

<b>Meeting #3</b>			
<b>#</b>	<b>Time</b>	<b>Item</b>	<b>Lead</b>
1	12:00	Introductions – New member – Bailit Health Purchasing	Kelly Ballas
2	12:10	Presentation – Purchasing Alignment: A Look at National Activity to Align Health Care Purchasing Across Payers	Beth Waldman, Bailit Health Purchasing
3	12:30	Reactor and Q&A – Reactor: Patrick O’Keefe	Kelly Ballas
4	1:00	Operationalizing the Principles of Oregon’s Coordinated Care Model: A High-Level Framework for Procurement and Contracting	Michael Bailit, Bailit Health Purchasing
5	1:30	Review of Environmental Scan Tool	Beth Waldman, Bailit Health Purchasing
6	1:45	Applying the CCM Principles – Communications Product	Lisa Angus
7	1:50	Public Comment	
8	2:00	Adjourn Meeting	

### **Meeting materials:**

- Presentation on Purchasing Alignment: A Look at National Activity to Align Health Care Purchasing Across Payers
- Operationalizing the Principles of Oregon’s Coordinated Care Model: A High-Level Framework for Procurement and Contracting
- Environmental Scan Tool – Carrier Interview Questions

# Purchasing Alignment

A Look at National Activity to  
Align Health Care Purchasing  
Across Payers

# Overview

- Nationally, some states are actively working to align purchasing across payers. This presentation is drawn from work Bailit did for the California Health Care Foundation.\*
- Today, we will look at:
  - Who is aligning?
  - What are they aligning?
  - What have been the challenges?
  - What are the lessons learned?

\* Full report available at:

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/A/PDF%20AllTogetherCoordinatingPurchasing.pdf>

# Coordinated Purchasing Defined

- What do we mean when we say “Purchasing”?
  - Procurements and contracting with health plans and other related services (e.g., pharmacy benefit management, actuarial services)
  - Assessment of health plan performance
  - Management of health plan performance
- Focus is on the impact of alignment on health plans, providers, and consumers
- Coordination can happen in many different ways
  - Shared staff
  - Shared contracting
  - Shared strategies

# Why Should States Try to Coordinate Purchasing Across Public and Private Payers?

- Common interests among purchasers
  - Improved quality
  - Improved efficiency
  - Reduced costs
- By working together they can enhance market leverage to accomplish goals
  - Aligned delivery system strategies (e.g., PCMH)
  - Aligned payment reform strategies (e.g., same incentive structures)
  - Aligned performance measurement (e.g., reduced administrative burden; more information and focus for providers; improved access or patient satisfaction)
  - Improved population health (e.g., reduced risk factors and chronic conditions)

# Examples of Coordinated Purchasing Activities: Operational Activities Across State Agencies

- States have aligned activities by using:
  - Common vendors:
    - Pharmaceutical benefits manager (PBM)
    - Health Plans
    - Dental and vision providers
  - Shared staff or contractors:
    - Actuarial and audit
    - Management positions
    - Policy staff
  - Shared infrastructure:
    - Claims system
    - Document imaging software
    - Data warehouse

# Examples of Coordinated Purchasing Activities: Procurement and Contracting Strategies

- States and employers may align through shared goals that implement separately or through common language
- Examples of common strategies/language exist in number of states (MA, MN, NY, NV, WA)
  - Delivery System Reform
    - Common PCMH strategies and support
  - Clinical strategies
    - Utilization management
    - Preferred drug list
  - Performance
    - Quality Improvement strategies
    - Performance measures
  - Payment
    - Joint approaches to payment reform
    - Common P4P methodology
    - Common fee schedule
    - Non-payment for never events and potentially avoidable care

# Example of Coordinating Body: Minnesota

- Interagency Executive Council helping to coordinate purchasing across state and employers
  - First introduced in 1991
    - Level of use and effectiveness has varied across governors but it has remained despite several leadership changes
    - State culture of collaboration to solve problems
  - Two-pronged use: to align state purchasers and to align state and employer purchasers
    - Ongoing vehicle for communication and dialogue across state agencies and employer purchasers
    - Examples of alignment across state and employers:
      - Use of National Business Coalition for Health's eValue8
      - Common implementation of Bridges to Excellence P4P

# Oregon Has Already Taken Significant Steps to Align its State Purchasing

- Policy director with joint responsibility for all OHA purchasing, include for Medicaid and state employees
- Common contracting language (patient safety commission; EHR incentive program)
- Combined medical and pharmacy policy development
- Aligned quality initiatives
- Planned alignment around the CCM
- Planned integration of customer service

# Broader Alignment Efforts

- Many states are engaged in multi-stakeholder efforts for aligned payment and delivery system reform
  - CMMI State Innovation Model (SIM) has provided a platform and reason for broader alignment between state and private purchasers
  - Often government serves as the convener of these efforts
    - The Vermont Green Mountain Care Board has facilitated a Medicaid-commercial ACO pilot with many shared design parameters, including operational standards, across payers.
    - Numerous multi-stakeholder PCMH initiatives across the US
  - Sometimes multi-stakeholder non-government conveners facilitate alignment at the request of the state
    - The Maine Health Management Coalition has facilitated a consensus process for a standard ACO measure set

# Barriers to Coordinated Purchasing Among State Agencies and Employers

- Most states and organizations work in own silos. It is outside of the culture of most organizations to coordinate with others.
- Other barriers include:
  - Loss of autonomy and authority
  - Loss of staff time/resources due to joint effort
  - Lack of trust across organizations
  - Difference in mission, values and priorities
  - Difference in population health care needs
  - Differences in payment and benefit design

# Lessons from Existing Efforts

- Alignment is hard work
  - Need to show that the effort is worth it (ROI) - a win for all purchasers
    - Improved quality
    - Reduced costs
  - Need to show benefits to providers and consumers as well, to keep momentum and pressure for continued alignment
  - Need to showcase results of alignment efforts to develop positive energy and ongoing culture of coordination to ensure long-term alignment

# Aligned Purchasing Strategies for State Agencies and Employers to Consider

- **Common core measure sets**
  - For transparency and accountability
  - For performance incentives
- **Common contractual requirements**
  - Implementation of specific delivery system reforms included in the CCM such as PCPCH
  - Aligned provider financial incentives
  - Aligned quality improvement projects such as efforts to reduce overuse
  - Aligned credentialing and other administrative processes

# Coordinated Care Model Alignment Work Group

## Operationalizing the Principles of Oregon's Coordinated Care Model: A High-Level Framework for Procurement and Contracting

This framework is designed to be used by self-insured purchasers, however similar language can be used for a fully-insured product. It is by design written at a relatively high level. The framework includes the critical elements of the model. For procurement purposes, additional detail would be required in most instances. Some concepts, such as value based benefit design, fall in a number of the elements. For the purposes of this framework we have included in one place. These CCM elements may be phased in over time if an employer is not able to implement all pieces at once.

Other content that falls outside of principles but would be important for effective purchasing activity, such as reporting, standards and value-based purchasing language re: contractual performance goals and contract management have not been included in this draft.

### I. Use best practices to manage and coordinate care

Application of evidence-based best practices of care delivery produces better care, improved outcomes and lower costs, as well as a positive patient experience.

- 1. Primary care clinician.** Plan Participant shall be required to identify a primary care clinician. The Administrator shall make sure that each Plan Participant has an identified primary care clinician and that the clinician establishes a relationship with every attributed Plan Participant if one does not already exist at the time of enrollment.
- 2. PCPCH.** The Administrator shall expect no less than XX% of contracted primary care practices to operate as a high-functioning Patient Centered Primary Care Home (PCPCH) or similar primary care transformation, hold PCPCHs accountable for performance, and shall support PCPCHs with needed payer-supplied data, not limited to high-risk patient lists, costs of referral providers, information regarding non-primary care utilization, and quality information, utilization and cost measures for attributed Plan Participants.
- 3. Team-based care.** The Administrator's contracted providers shall be required to provide patient-centered, team-based care across appropriate disciplines through the application of a common, shared care plan and clinical information exchange.
- 4. Care coordination.** The Administrator shall ensure the provision of care coordination for patients at high-risk of future intensive service use. Care coordination may be provided through a combination of PCPCHs, coordinated care

entities (such as CCOs or ACOs), and the Administrator. Where care coordination is available to a consumer through more than one organization, the Administrator shall ensure that these efforts are coordinated. Care coordination shall include integration of long term services and supports (LTSS) with needed health care services, and shall leverage community-based human services that address social determinants of health, including housing and employment and coordination of population health. (LTSS -Medicaid only).

5. **Behavioral/physical health integration.** Behavioral health and primary care services shall be integrated through the application of evidence-based best practices, including but not limited to co-location (including reverse co-location, which is defined as placement of primary care resources in community mental health settings), use of an integrated medical record, use of a shared treatment plan, and integrated payment.
6. **Clinical protocols.** Contracted providers shall be required to specify and implement clinical protocols that are reflective of evidence-based practice, designed to maximize patient health status, clinical outcomes and efficiency, and to eliminate overuse (waste). For example, a clinical protocol may include a treatment plan for treating an individual with COPD or stroke management.
7. **Formulary Development.** The Administrator shall develop a formulary design that includes prescription drug coverage for each therapeutic but is flexible enough to allow for access to products outside the formulary in special circumstance. The formulary should be reviewed and amended at minimum on an annual basis.
8. **Electronic health record (EHR).** Contracted physician providers shall be required to adopt and fully utilize electronic health records across care settings. Such providers shall implement systems to ensure data completeness and accuracy.
9. **Health information exchange.** Contracted physician and hospital providers shall be required to practice real-time electronic clinical information exchange across all care settings.
10. **Value Based Network Design.** Value-Based Network Design is the explicit use of employee plan benefits to create consumer incentives for use of high performance providers who adhere to evidence-based treatment guidelines.
  - a. **Tiered network.** The Administrator shall make available to the Purchaser a benefit design that varies cost-sharing by provider performance. For example, the highest performing providers and/or centers of excellence are placed in Tier 1 with the lowest cost-sharing, while the lowest performing providers on a set of quality metrics are placed in Tier 3 with the highest cost sharing.
  - b. **High Performing network.** The Administrator shall make available to the Purchaser a high performing network that is limited to providers who have distinguished themselves based on evidence-based, statistically meaningful

and risk-adjusted measures of quality as well as risk-adjusted measurement of cost and efficiency.

**11. Use of telemedicine.** The Administrator shall support provision of covered telemedicine services.

## **II. Share responsibility for health**

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and patients/consumers can share responsibility and decision-making for care, while coming to joint agreement on accountability for individual health behaviors.

- 1. Shared decision-making.** Contracted providers shall be expected to make shared decision-making a standard of care with patients and their family members (as appropriate), utilizing tools such as personal health self-assessments and technologies such as video and web-based decision aids to support the process.
- 2. Benefit design incentives for preventive care.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for evidence-based screenings, well-child visits and other preventive care services. For example, incentives could include enriched benefit coverage, reduced cost-sharing and “extras” such as car seats and gym memberships
- 3. Benefit design incentives for health behaviors.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for personal health behaviors and improved health status using evidence-based strategies relating to diet, exercise, smoking and medication adherence. For example, incentives could include enriched benefit coverage, reduced cost sharing and “extras” such as gym memberships.
- 4. Benefit design for evidence-based services.** The Administrator shall propose for Purchaser consideration a benefit design that varies cost-sharing for services that are nationally recognized as over-used or being driven by supply and/or physician preference rather than evidence-based practice. For example, this may include incentivizing the use of physical therapy without cost-sharing for back pain prior to receiving an MRI or reducing cost-sharing for prescription drugs related to chronic conditions such as diabetes.
- 5. Patient activation.** Contracted providers shall be expected to utilize strategies that activate patients to take charge of their health and any chronic condition needing management. Such strategies shall include provider training, use of standardized assessment instruments and differentiated patient activation strategies based on assessment results.
- 6. Health Risk Assessment.** The Administrators shall provide for a Health Risk Assessment to be completed by each adult Plan Participant.

### III. Measure performance

Comprehensive performance measurement, aligned across payers, supports identification of performance improvement opportunities and provider performance accountability purchasers while easing the burden of reporting for providers.

- 1. Aligned measure set.** The Administrator shall adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup (<https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf>) or future consensus document, which aligns measures across major public and private payers, including commonly defined measures in each of the following domains and stratified by major subpopulations: a) access, b) quality, c) patient experience, d) patient activation, e) service utilization, and f) cost. These performance measures shall be reported to the All Payer All Claims (APAC) Reporting Program.
- 2. Administrator health informatics.** The Administrator shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients at risk for future high-intensity service use.
- 3. Provider health informatics.** The Administrator shall require contracted providers operating under population-based contracts to perform analysis of integrated claim and clinical data to identify a) population characteristics, b) variation in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients in need of evidence-based services, e) patients at high risk of future high-intensity service use
- 4. Provider-level measurement.** The Administrator shall require contracted providers to measure performance at the clinician, practice team and/or practice site, and organizational levels.
- 5. Administrator-level measurement.** The Administrator shall measure performance across all provider types and providers with meaningful volume for the Administrator's book of business.
- 6. Population measurement adjustment.** The Administrator shall apply clinical risk adjustment techniques when measuring provider performance and utilize socio-economic risk-adjustment techniques to the extent available.

### IV. Pay for outcomes and health

Alternative payment methodologies (APMs) such as population-based payment, episode-based payment, and offering incentives for quality outcomes instead of volume-based fee methodologies all support better care and better lowered cost growth. Our intent is to increase use of these alternative payment methodologies over time.

- 1. Population-based contracting.** The Administrator shall take such actions as are necessary to achieve the following population-based contracting requirements:
  - By the end of calendar year 20xx, claims for at least 30 percent of insured covered lives shall be paid under a population-based contract with shared savings, or with risk sharing.
  - By the end of calendar year 20xx, claims for at least 45 percent of insured covered lives shall be paid under a population-based contract with shared savings, and claims for at least 10 percent of insured covered lives shall be paid under a population-based contract with risk sharing.
  - By the end of calendar year 20xx, claims for at least 60 percent of insured covered lives shall be paid under a population-based contract with shared savings, and claims for at least 20 percent of insured covered lives shall be paid under a population-based contract with risk sharing.
- 2. Pay providers, including both those operating under population-based contracts and those not, differentially according to performance.** The Administrator shall evaluate and implement successful programs to differentiate providers who meet or exceed state or national standards for quality and efficiency. Compensation paid to effective and efficient providers should reflect their performance and result in market efficiencies and savings to purchasers and payers. Examples include quality-based incentive payments, differential fee schedules, and fee increases at risk based on provider performance.
- 3. Design payment and coverage approaches that cut waste while not diminishing quality, including reducing unwarranted payment variation.** The Administrator shall evaluate and implement successful approaches to payment that are designed to cut waste while not diminishing quality. Examples include, but are not limited to, reference pricing, non-payment for avoidable complications and hospital acquired infections or lower payment for non-indicated services, warranties on discharges for patients who undergo procedures.
- 4. Support primary care.** The Administrator shall support Patient Centered Primary Care Home (PCPCHs) or similar primary care transformation, ensuring that the level and method of compensation support an effective preliminary care infrastructure, through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.

## **V. Provide information so that patients and providers know price and quality**

Readily available, accurate, reliable and understandable cost and quality data can help patients understand health care plan choices, and share responsibility in treatment, care

management, and other health care decisions. Increased transparency on price and quality can also lead to increased accountability for providers.

- 1. Fully disclose quality performance to facilitate comparisons of providers.** The Administrator shall develop and implement a strategy to report the comparative performance of Providers, using the most current nationally-recognized or endorsed measures of hospital and physician performance. Information delivered through the Administrator's provider ranking programs should be meaningful to Plan Participants and reflect a diverse array of provider clinical attributes and activities. Information available to Plan Participants should include, but not be limited to, provider background, quality performance including specific to high-volume interventional services, patient experience, volume, and should be integrated into and accessible through one forum providing Plan Participants with a comprehensive view.
- 2. Fully disclose prices to facilitate price comparisons of providers.** The Administrator shall, where permitted, make transparent and available for use by Company and its Plan Participants, including those in consumer-directed plans, Plan- and any Purchaser-specific price information for services that represent at least 80% of the Administrator's medical spend in all markets, including full disclosure of the prices it is paying to Providers. The disclosed information shall be based on the contracted price of specific procedures and services including, without limitation, reasonable and customary estimates, to facilitate Plan Participants' informed choice of treatment and care decisions.
- 3. Combine projected price information with Plan Participants' benefit design.** The Administrator shall identify and engage third-party vendors, if any are necessary, to enable the Administrator to integrate tools providing information about the price of specific services with information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans. The Administrator shall align with future transparency efforts led by the Oregon Insurance Division or other state entities.

## **VI. Establish a sustainable rate of growth**

Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through a fixed rate of growth approach is foundational to health care transformation in Oregon.

- 1. Population cost growth.** Population-based contracts shall include a provision that the risk-adjusted annual increase in the total cost of care for services reimbursed under the contract shall be informed by the efforts of the Sustainable Health Expenditure Work Group.

2. **Provider price growth.** Provider contracts, including but not limited to hospital and physician contracts, shall include a provision that agrees on rates, and quality incentive payments for each contract year, informed by the work of the Sustainable Health Expenditure Work Group.

## Defined Terms

**Administrator** – the entity responsible for providing third party Plan administration services on behalf of an employer purchaser and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Plan Participants.

**Behavioral Health** – services related to both mental health and addiction

**Clinical Protocols** – standardized tools designed for a particular chronic condition or procedure that provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.

**Employer** – sponsor of a group health plan with specified benefit coverage through the Administrator.

**Patient Centered Primary Care Home (PCPCH)** – a primary care practice that meets the State criteria for a PCPCH as defined at <http://www.oregon.gov/oha/pcpch/Pages/standards.aspx>.

**Plan** – the set of benefits offered by the Employer through the Administrator through an agreement.

**Plan Participant** – employees, dependents and retirees of the Employer who are eligible to receive their health benefits under the Plan.

**Primary Care Clinician** – a Provider that focuses his or her practice on the provision of primary care; a Primary Care Clinician may include pediatricians, family physicians, nurse practitioners, internists, and based on a Plan Participant's diagnoses, may also include a specialty physician upon agreement by that physician and approval by the Administrator.

**Provider** - primary care and specialty physicians, hospitals, outpatient and ancillary facilities participating in the Administrator's network for the purposes of this Plan.

# Coordinated Care Model – Carrier Interview Questions

## Overview

The vision of Governor Kitzhaber and the Oregon Health Policy Board is that broader adoption of the Coordinated Care Model (CCM) principles will unite Oregon’s markets in the drive towards achieving better health, better care, and lower costs. To begin to understand the current health insurance market landscape, the Office of Health Policy and Research (OHPR) will conduct interviews with carriers to understand their commitment to the CCM principles. Carrier interviews will also seek to comprehend the programmatic and operational efforts to adopt the model, including challenges, needs, and the resources available to facilitate the spread of the CCM. A separate set of questions is under development for purchasers.

Through these questions, the State will aim to obtain information from carriers in the following areas:

- Carrier programs/operations supporting the CCM;
- Provider (hospital and physician) interest and readiness;
- Challenges/barriers for further spread;
- Needs of the market segment constraining the ability to spread the model; and
- Resources available to facilitate the adoption of the model.

## General Plan Information

We would like to understand the market segments served by your plan and how many lives you serve in each segment.

Market	Covered Lives	Sample Employers
Individual		
Small Group (fully insured)		
Large Group (fully insured)		
Self-Insured		
Medicaid		
Medicare Advantage		

## Coordinated Care Model (CCM)

As you know, the state has developed a Coordinated Care Model and implemented it for the Medicaid program via contracts with Coordinated Care Organizations. [Review CCM Model with interviewee]

1. Are you familiar with the Coordinated Care Model? If yes, what aspects of the model are of interest to you? Are there aspects of the model that you are not inclined to implement within your offerings?

2. [If no, provide an explanation.] Do you believe, based on what I've described, that your organization is utilizing similar principles in the coverage you are providing. If not, where are the points of divergence?

#### *Strategies to Change Patient Behavior*

We are interested in activities that you have undertaken that may influence a consumer's behavior in terms of choosing providers and engaging in care.

1. Please describe your efforts to implement patient (member) behavior change strategies, including any notable employee or provider reaction to such efforts:
  - a. Transparency of provider performance on:
    - i. Quality
    - ii. Cost or efficiency, including relative to a member's deductible and coinsurance
  - b. Tiered networks
    - i. Please describe the patterns of service delivery in your market and whether there are any providers that are seen as "must haves" in any provider network.
  - c. High Performing (select) networks
  - d. Value-based benefit design
    - i. Incentives for use of preventive services
    - ii. Incentives for healthy behaviors
    - iii. Incentives for use of evidence-based services
  - e. Wellness programs and/or tools
  - f. Shared decision making tools
  - g. Patient activation or engagement in management of health conditions

#### *Payment and Delivery Innovations*

We are interested in understanding the activities you have undertaken to move from fee-for-service payment; support providers in transformation to new payment and delivery models, and the financial and non-financial incentives that you have used to bolster provider accountability.

2. Has your organization participated in any reforms to the fee-for-service payment system as described below?
  - a. Implementation of non-payment and/or reporting of adverse events?
  - b. Use of supplemental payments for PCPCH (Medical Home) and/or clinical care management programs?
  - c. Institution of reference pricing for treatments and/or procedures?
3. Has your organization encouraged (through contractual requirements or through financial or non-financial incentives) and supported (with reports, payment, TA or other resources) the following activities among providers?

- a. Care coordination and continuity of care for members, especially for individuals with complex needs
  - b. Patient-centered models of care
  - c. Integration of physical health, mental health, and addictions services
  - d. Programs for high-risk members (e.g., case management, disease management, pharmacy benefit management)
4. Please describe your organization's efforts in the area of Health Information Technology that have resulted in increased access and sharing among providers and care delivery improvements.
  - a. Adoption and meaningful use of EHRs and health information exchange
  - b. Telehealth programs
  - c. Provision of data, reports and/or analytics tools to contracted providers
  - d. Other efforts
5. Please describe any intent or actions to adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup. If no actions have been taken, are you open to using a common measure set in your performance-based contracts with providers?
6. Please describe your organization's past and current attempts at payment innovation and provider accountability (P4P, PCPCH supplemental payment, shared savings and/or risk, capitation, bundled payment), including the scale and impact of the efforts. What percentages of your covered lives or payments roughly fall under one or more of these models at present?
7. What, if anything, have you done in your contracts with providers to slow the effects of provider price growth on medical trend?