Oregon Healthcare Workforce Committee

AGENDA

January 25, 2012

Wilsonville Training Center, Room 111-112
29353 SW Town Center Loop E, Wilsonville, Oregon 97070
9 am – Noon

#	Time	Agenda Item	Presenter(s)	Action Item
1	9:00	Welcome	Chairs	
2	9:05	Approval of October 27 meeting summary	Chairs	X
3	9:05	Updates	Lisa Angus Jo Isgrigg	
4	9:10	Review of CCO implementation proposal from a health care workforce perspective ▪ *Are there opportunities to strengthen language around workforce development, staffing models, new competencies, scope of practice, etc.?* ▪ *What information should be collected or evaluation question should be posed about potential changes in staffing levels, roles, team make-up, etc.?*	Chairs Lisa Angus	
5	9:50	Next steps for Workgroup 1 (Workforce models and competencies for new systems of care) ▪ *Prioritization of recommendations* ▪ *Possibility of gathering additional input?* ▪ *Options for moving recommendations to implementation?*	David Nardone and Chairs	
6	10:10	Break		
7	10:25	Review of Medical Liability reform options from a health care workforce perspective ▪ *Strengths or weakness of options for workforce development (balanced with cost containment, patient safety, and equity)*	Jeanene Smith (OHPR) and Chairs	
8	10:55	Input on recommendations for NTHWs ▪ *Input on recommended training hours, supervision, etc.?* ▪ *Appropriate entity to approve training programs? To maintain registry of NTHWs?*	Donna Larson and Chairs	
9	11:15	Brief reports from / guidance for: ▪ Workgroup 2 (SB 879) ▪ Workgroup 3 (HB 2366) ▪ Workgroup 4 (Adverse impact)	Workgroup Leads	
10	11:45	Public Comment	Chairs	
11	12:00	Adjourn		

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Oregon Healthcare Workforce Committee
Meeting Summary

October 27, 2011
1:30 – 4 pm

Committee Members in Attendance

John Moorhead (Chair, via phone)
Ann Malosh (Vice-Chair)
Bonnie Bender (via phone)
Paula Crone
Lisa Dodson
Sara Hopkins-Powell
Mary-Rita Hurley (via phone)
Terri Johanson (via phone)
Donna Larson
David Nardone
Daniel Saucy
Jennifer Valentine

OHA and OWHI Staff in Attendance

Jo Isgrigg (OHWI)
Jennifer Swendsen (OHWI)
Lisa Angus (OHPR)

Committee Members not in Attendance

Peter Angstadt
June Chrisman
Lita Colligan
Kelly Morgan
Marcus Mundy
David Pollack
Mark Richardson
Karen Sanders
Kristen Simmons
Kathyleen Tomlin
Judith Woodruff

Meeting Summary
(**Committee actions or decisions in bold**)

Ann Malosh convened the meeting. She noted that the meeting agenda consisted largely of reports from the various workgroups and encouraged Committee members to make comments, give feedback and/or suggest new directions for any of the workgroups. The workgroups were formed to give each deliverable a dedicated project team but every Committee member should consider her- or himself a part of each workgroup.

The Committee approved the July 27, 2011 meeting summary.

General Updates

- The four workgroups that were convened by the Governor and the Health Policy Board to advise OHA on some of the design elements for Coordinated Care Organizations

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(CCOs) have been meeting monthly since August. Each has one meeting left in November. The CCO Criteria workgroup's November meeting (11/15 from 6-9 pm in Salem) will focus on several workforce relevant topics: delivery system components and capacities, and coordination of care.

- OHPR has met with three new licensing boards in preparation for including their data in the Oregon Healthcare Workforce Database: the Board of Licensed Professional Social Workers; the Board of Professional Counselors and Therapists; and the Board of Psychologist Examiners. HB 3650 directed OHA to expand the database but does not compel new boards to make participation a requirement for licensure; OHPR will assess the response rate with voluntary participation.
- The state Primary Care Office has received a 2-year grant to support retention of ARRA-funded National Health Service Corps scholars and clinicians in underserved communities. The Office is partnering with the Primary Care Association, the Office of Rural Health, the Oregon AHEC office and OHWI to provide technical assistance to sites and develop and pilot test a retention toolkit.
- OHWI will be convening a small group, with leadership from Kelly Morgan, to discuss investments in healthcare professional training and jobs.
- OHWI is also convening the Portland WIB, Portland Community College and some participants from the Primary Care Association's medical home pilot sites to discuss M.A. curricular changes.

<u>Non-Traditional Health Workers Subcommittee</u>

Donna Larson gave an updated on this Subcommittee, which was formed in September at the request of the Health Policy Board. Donna is co-chairing the Committee along with Teresa Rios-Campos of the Multnomah County Community Capacitation Center. Donna noted that:

- The group's charge is to develop criteria for three types of professionals named in HB 3650: community health workers, personal health navigators, and peer wellness specialists. Its deliverables are focused on scope (roles), training, and the question of certification. The final recommendations will need to be flexible and adaptable and applicable to any CCO.
- The workgroup is large and very engaged. As an initial step, the group fielded an online survey to ask existing workers about their skills, roles, and training and received over 560 responses.
- The group has a very short timeframe with draft recommendations due in January. At the meeting earlier in the day, the group discussed the question of certification (should individual workers be certified? Or should training programs be certified? Or is certification unnecessary?) and did not yet come to consensus.

Comments and suggestions from other Committee members included these:

- Jennifer Valentine, who is also on the Subcommittee, commented that the group seemed to be moving toward certifying training rather than individuals but that questions remained about how best to ensure quality and safety.

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- More than one member commented that they are frequently asked what the Workforce Committee is doing about this segment of the workforce. Members encouraged the Subcommittee to move quickly, partially because of a concern that proprietary or other educational institutions will launch training programs that may not be transferrable or solid.
- Members suggested keeping the Office of Degree Authorization in the loop.
- While emphasizing the importance of on-the-ground experience for real learning, members also noted that internship or clinical placement spots were already in short supply.

Committee members approved the Non-Traditional Health Workers Subcommittee charter.

<u>Workgroup 1: Workforce models and provider competencies for new systems of care</u>

David Nardone gave an update on the work of this group and presented the group's draft report. He noted that the report was not yet done and asked the Committee for suggestions to strengthen the report. Key points included:

- Process – the group had 3 or 4 calls to establish a set of interview questions for key informants in education, practice, and policy across Oregon. Then members of the group conducted about 30 telephone interviews, with invaluable transcription assistance from Ann Malosh's staff at Linn-Benton CC. OHPR did a small contract with a qualitative analyst at Providence to help with coding and analyzing the interview data and Jo Isgrigg contributed a wealth of background literature for the draft report.
- The draft report calls for a dramatic expansion of team-based, interprofessional care across the state. Draft recommendations for supporting this expansion include: reimbursement reform (again); development of competencies and role descriptions for new categories of workers (e.g. non-traditional health workers); coordination among educational programs to endorse and train toward a common set of interprofessional competencies; faculty development to increase their exposure to new systems of care; and several others.
- David highlighted some barriers to implementation of team-based care that he had noted in his analysis of the interviews including: difficulties with rural recruitment and retention; lack of tangible and immediate incentives for leaders in practice and education to collaborate on curricula or training; lack of incentives for specialists to be involved in primary care home models; and slow-moving reimbursement reform.

Comments and suggestions from other Committee members included these:

- Members discussed the idea of a follow-up survey of employers and practices to help prioritize among (and get buy-in for) the group's recommendations.
- The draft report notes that health professions faculty generally have few opportunities to gain experience with emerging care models. The suggestion was made to follow up with the interviewees to secure agreements to create faculty development opportunities.

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- Several members noted that practitioners and educators have many questions about what is coming in Oregon with primary care homes, CCOs, and health reform in general. It would be helpful for OHA to create webinars or other communication materials to educate people and let them know what first steps they can take.
- It was noted that dentistry is not discussed much in the draft report. Reimbursement is a large concern for dentistry but capitation-like models may not be appropriate. Community health workers and similar professionals mat be a promising way to connect people to the system.

Workgroup 2: Standardized Pre-requisites for student clinical placement

Terri Johanson gave an update on the work of this group, which is tasked with developing standard prerequisites (e.g. immunizations, criminal background check, drug testing) for student clinical placements.

- The group held its first large stakeholder meeting on Oct. 19th. Attendees included representatives from a range of educational programs, clinical host sites (all large health systems), and regulatory agencies.
    - Terri asked Committee members for additional participant suggestions, particularly representatives from smaller clinics, long-term care, and legal or risk management.
- The group fielded a short online survey ahead of time to help set the context for the meeting. Educational institutions' primary concerns related to clinical placement are the wide variety and variability of requirements, programs and timeline. Clinical host sites' primary concerns were lack of capacity and non-compliance with their requirements.
- The first meeting focused on identifying goals and issues to be addressed; the second meeting (likely in January) will focus on specific standards. The group will be collecting information on existing requirements between November and January.
- At the October meeting, participants introduced some topics slightly beyond the group's scope, particularly the issue of out-of-state programs that have students seeking clinical placements in Oregon. Some programs support their students and others leave them to find their own placements.

Comments and suggestions from other Committee members included these:

- Need to think about how to involve proprietary schools in this work. Several were invited to the meeting but did not attend and there are no proprietary schools represented on the Committee. The 4th workgroup will be talking to some proprietary schools in early December about adverse impact, but clinical rotation capacity is an aspect of that issue.
- Ann Malosh cautioned the group about taking on more than its charge, noting that developing and getting agreement on standards would be an accomplishment in itself.

Workgroup 3: Strategic Plan for Primary Care Provider Recruitment

Lisa Dodson gave an update on the work of this group, which is tasked with developing a statewide strategic plan for primary care provider recruitment:

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- The group has a fantastic intern who has completed a draft environmental scan (included among the meeting materials). Notable in the scan is the fact that many states are trying to address the same issues and that stakeholders are often in competition with each other.
- The group has organized some potential strategies from the environmental scan on a 2x2 grid to look at relative cost and effort. The group's intent is to have a meeting with some key stakeholders in December to review the environmental scan and grid and generate some ideas of where collaboration might be most feasible and rewarding. The group will seek broader input after that, perhaps via an online survey.
    - The group has a list of potential stakeholders but would appreciate additional suggestions, especially from the business community.

Comments and suggestions from other Committee members included these:

- Debt management is a significant issue in recruitment. A loan forgiveness bill did pass last session, indicating that the Legislature recognizes the importance of student debt in health professional recruitment.

Workgroup 4: Revise adverse impact regulation

Sara Hopkins-Powell gave an update on the work of this group.

- The group sent a letter and case statement to Jennifer Diallo, the current Administrator of the Office of Degree Authorization (ODA), and had a productive meeting with her. She seems willing to move the conversation forward. She noted that the issue goes beyond public vs. non-public programs: the current adverse impact policy does not give ODA the ability to manage conflict or competition between two private or proprietary schools.
- Ms. Diallo has communicated with her Board and the Committee has communicated with the Governor's office. The next step is a meeting with some representatives from private or proprietary schools in early December.
- At Ms. Diallo's suggestion, the group also spoke to an advisor in Senator Merkley's office. The Senator has an interest in making sure that schools are transparent about what kind of accreditation they possess, so that students do not go through training only to discover that their education does not meet licensing board requirements.

There were no comments or suggestions from other Committee members.

Public Comment

Mark Stevens, Division Chief of the Tualatin Valley Fire District, testified on behalf of the EMS Section of the Oregon Fire Chiefs Association. The Association is interested in collaborating with health system partners on common goals such as improving community health, lowering 911 call volume and hospital readmits, and getting patients the right care, at the right time, and in the right place.

Ann Malosh adjourned the meeting at 4:00 P.M.

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Coordinated Care Organization Implementation Proposal

House Bill 3650
Health Care Transformation
January 10, 2012

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Oregon Health Authority

Oregon Health Policy Board

The nine-member Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for the Oregon Health Authority. The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health. Board members are nominated by the Governor and must be confirmed by the Senate. Board members serve a four-year term of office.

Eric Parsons
Chair, Portland

Lillian Shirley, BSN, MPH, MPA
Vice-Chair, Portland

Michael Bonetto, PhD, MPH, MS
Bend

Carlos Crespo, MS, DrPH
Portland

Felisa Hagins
Portland

Chuck Hofmann, MD, MACP
Baker City

Joe Robertson, MD, MBA
Portland

Nita Werner, MBA
Beaverton

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CCO Implementation Proposal
House Bill 3650 Health Care Transformation

1. Executive Summary

Health care costs are increasingly unaffordable—to businesses, individuals, as well as the federal and state government. The growth in Medicaid expenditures far outpaces the growth in general fund revenue, yet there has not been a correlating improvement in health outcomes.

In 2011 the Oregon legislature and Governor John Kitzhaber created Coordinated Care Organizations (CCOs) in House Bill 3650 aimed at achieving the triple aim of improving health, improving health care and lowering costs by transforming the delivery of health care. The legislation builds on the work of the Oregon Health Policy Board since 2009. Essential elements of that transformation are:

- integration and coordination of benefits and services;
- local accountability for health and resource allocation;
- standards for safe and effective care; and
- a global Medicaid budget tied to a sustainable rate of growth.

CCOs are community-based organizations governed by a partnership between providers of care, community members and those taking financial risk. A CCO will have a single global Medicaid budget that grows at a fixed rate, and will be responsible for the integration and coordination of physical, mental, behavioral and dental health care for people eligible for Medicaid or dually eligible for both Medicaid and Medicare. CCOs will be the single point of accountability for the health quality and outcomes for the Medicaid population they serve. They will also be given the financial flexibility within available resources to achieve the greatest possible outcomes for their membership.

CCOs are the next step forward for Oregon's health reform efforts that began in 1989 with the creation of the Oregon Health Plan. Today's managed care organizations, mental health organizations, and dental care organizations that serve our state's Medicaid population have done a good job in keeping health care costs down, but the current structure limits their ability to maximize efficiency and value by effectively integrating and coordinating person-centered care. Each entity is paid separately by the state and manages its distinct element of a client's health. Additionally, the current payment system provides little incentive for the prevention or disease management actions that can lower costs, and OHP clients face a sometimes dizzying array of plans and rules while health care costs continue to outpace growth in income or state revenues.

Conventional wisdom is that there are three approaches to controlling what is spent on health care: reduce provider payments; reduce the number of people covered; or reduce covered benefits. Over the years these approaches have proven unsuccessful in reducing the actual cost of care and can squelch investments in health improvement that lead to lower future costs.

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In the creation of Coordinated Care Organizations, HB 3650 lays the foundation for a fourth pathway: rather than spending less into an inefficient system, change the system for better efficiency, value and health outcomes.

To implement CCOs in our state, lawmakers called on the Oregon Health Authority to develop a proposal for governance, budgeting, and metrics. That proposal has been developed through the Oregon Health Policy Board and is the result of the work of the board and four work groups comprising 133 people who met over four months, a series of eight community meetings around the state that brought input from more than 1,200 people, and public comment at the monthly Oregon Health Policy Board meetings.

Financial Projections for Greater System Efficiency and Value
There is ample evidence from initiatives in our local communities that the kind of transformation pointed to by HB 3650 can improve health outcomes and lower costs. National efforts are showing the same results.

Included in the proposal is work conducted on behalf of OHA and the Oregon Health Policy Board by Health Management Associates (HMA) estimates that total Medicaid spending in Oregon can be reduced by over $1 billion over the next 3 years and $3.1 billion over the next five years by transforming the way we pay for and deliver health care. They initially assume a phase-in of savings of 10% to 20% in implementation of year one, moving to 40% to 50% in the 2013-2015 biennium. In year one, this equates to $155 million to $308 million in total fund ($58 million to $115 million general fund) cost reductions, net of new investment. HMA believes these projections are conservative as there are certain opportunities that would move the system beyond what we currently understand as well-managed. It is also possible that greater potential savings could be achieved with faster implementation. Full details of HMA's analysis are included in the proposal.

This proposal outlines operational and key qualification guidelines for CCOs as recommended by the Oregon Health Policy Board, including:

- *Global budget*: CCO global budgets will be developed by OHA to cover the broadest range of funded services for the largest number of beneficiaries possible. OHA will construct the CCO global budgets starting with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets will include services that are currently provided under managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources toward the most efficient forms of care.

Once CCOs are phased in, the quality incentives will be incorporated in the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

- *Accountability*: CCOs will be accountable for outcomes that bring better health and more sustainable costs. HB 3650 directed CCOs be held accountable for their performance through public reporting of metrics and contractual quality measures that function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the direction of HB 3650. Accountability measures and performance expectations for CCOs will be introduced in phases to allow CCOs to develop the necessary measurement infrastructure and enable OHA to incorporate CCO data into performance standards.

  An external stakeholder group established a set of principles and recommendations for dimensions of measurement for OHA to use as a guide when establishing outcomes and quality metrics. Upon Legislative approval to go forward, the next step is to establish a committee of technical experts from health plans and health systems to further define these metrics and a reporting schedule. The technical work group will be asked to establish both minimum expectations for accountability as well as targets for outstanding performance.

- *Application process*: Beginning in spring/early summer, prospective CCOs will respond to a non-competitive Request for Applications (RFA) much like the process developed by the federal government for Medicare Advantage plans. The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

- *Governance*: CCOs will have a governing board with a majority interest consisting of representation by entities that share financial risk as well as representation from the major components of the health care delivery system. CCOs will also convene community advisory councils (CAC) to assure a community perspective and a member of the CAC will serve on the CCO governing board.

- *CCO criteria*: In their applications for certification, CCOs will demonstrate how they intend to and carry out the functions outlined in HB 3650 including:
  - Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;
  - Ensuring member rights and responsibilities;
  - Working to eliminate health disparities among their member populations and communities;

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- Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;
- Developing a health information technology (HIT)infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency

Assuming legislative approval, CCO criteria, the Request for Applications (RFA), and a model CCO contract will be publicly posted in spring 2012 so that communities interested in forming CCOs can begin preparing applications.

The Oregon Health Authority and the Oregon Health Policy Board are poised to begin implementation of the transformational change represented in HB3650.

Timeline

Federal permissions submitted	March 2012
CCO Criteria publicly posted	Spring 2012
Request for Application (RFA) and model contract posted	Spring 2012
Letters of intent submitted to OHA	Spring 2012
Evaluation of initial CCO applications	Spring/early summer 2012
First CCOs certified	June 2012
First CCOs begin enrolling Medicaid members	July 2012

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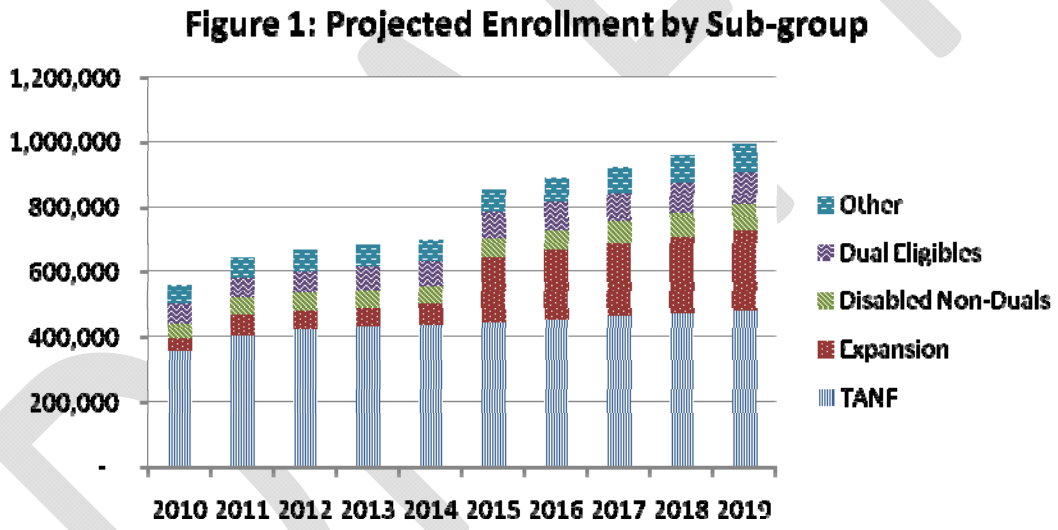
2. Existing Market Environment and Industry Analysis

Target Population

Projected Enrollment

The target population includes all current and future Oregon Health Plan (OHP) enrollees. Between 2010 and 2011, enrollment grew rapidly, due primarily to growth within the expansion group. OHP staff estimates project modest (3%) annual enrollment growth through state fiscal year 2014, followed by a rapid jump between 2014 and 2015 when the Affordable Care Act Medicaid expansion goes into effect. While the vast majority of new enrollees are expected to be non-disabled adults, OHP is projecting that the annual rate of growth among the disabled and dual-eligibles, which is approximately 6 percent (excluding the year of the Medicaid expansion), will be roughly three times that of the TANF-related population's 2%. This trend is critical, as the disabled and dual-eligible populations are, on average, far more costly than their TANF-related counterparts, and also stand to benefit most from effective care management.



The following table shows the demographic distribution of the Oregon Medicaid population in 2011. The racial/ethnic makeup of the population has remained virtually unchanged over the last three years. The age profile of the Oregon Medicaid population has also remained stable over the last three years, though there has been a slight shift from the 0-18 age group to the adult group. This trend is expected to be much larger beginning in 2014, as the majority of new Medicaid enrollees will be previously uninsured adults. Approximately 56 percent of Medicaid enrollees are women and 44 percent are men. While this distribution has remained constant over the last several years, it is expected to shift somewhat toward men when the 2014 expansion is implemented.

Table 1: Oregon Medicaid Demographics (2011)

Demographic	% (2011)
Race/Ethnicity	
White	61%
African American	4%
Hispanic or Latino	22%
Asian, Native Hawaiian or Other Pacific Islander	3%
American Indian or Alaska Native	2%
Other/Unknown	8%
Age	
0-18	56%
19-64	37%
65+	7%
Gender	
Male	44%
Female	56%

Table 1: Data were extracted from the demographic reports published by the Oregon Health Plan, July 2011.

Current Delivery System for Target Population

The current OHP program is fragmented, resulting in diluted accountability for patient care and likely duplication of infrastructure and services. Care is delivered through a system that includes three kinds of health plans (16 physical health organizations, 10 mental health organizations and eight dental care organizations), while some individuals continue to receive care on a fee-for-service basis. Specifically:[1]

- Approximately 78% of OHP clients are enrolled in physical health managed care.
- Nearly 90% of OHP clients are enrolled in managed dental care.
- Approximately 148,000 clients not enrolled in managed care receive services on a Fee-for-Service (FFS) arrangement – providers bill the state directly for their services based on a set fee schedule. Some providers receiving FFS also get a case management fee (in areas where there are no managed care plans).
- 88% of OHP enrollees are enrolled in capitated mental health organizations (MHOs). In many cases, the state provides capitated mental health organization (MHO) payments to the counties and the counties administer the programs. The counties function as the MHO, bearing full risk for the services, and contract with panels of providers to provide direct services to enrollees. Addiction services for Medicaid clients are covered in fully capitated health plans, not through MHOs or counties.

Please see Appendix A for detailed information on current plan types and service areas.

[1] Oregon Health Authority. Oregon Health Policy Board Meeting slides, January 18, 2011

Population Characteristics and Health Status

The need for more effective service integration and care management for OHP enrollees is evident in statewide and Medicaid-specific data. This section provides an overview of several key indicators of population health. Many of these indicators are also reflective of major cost-drivers within the Medicaid program.

- *Perinatal Indicators.* Maternal and child health indicators are important factors in assessing the relative health of a community. Risk factors for poor birth outcomes such as low birth weight, short gestation, maternal smoking, inadequate maternal weight gain during pregnancy and substance abuse can often be addressed as a woman receives prenatal care.
- *Chronic Conditions.* Experts estimate that chronic diseases are responsible for 83 percent of all health care spending.[2] Health care spending for a person with one chronic condition on average is two and a half times greater than spending for someone without any chronic conditions.[3]
- *Smoking.* Direct Oregon Medicaid costs related to smoking are an estimated $287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon.[4] While overall tobacco use rates in Oregon are below national levels and trending downward, adult Medicaid clients are nearly twice as likely to smoke as Oregon adults in general.[5] Specifically, 37 percent of adult Medicaid clients smoke, compared to 17 percent of Oregon adults. In addition, studies have shown that economic status is the single greatest predictor of tobacco use.[6]
- *Obesity.* Similarly, Medicaid payments for obesity-related care accounted for nearly nine percent of Medicaid costs between 2004 and 2006, a figure that has likely grown as obesity rates have increased.[7]

The following chart show statewide trends in perinatal indicator rates for the Medicaid population. Teen birth rates and low birth rate babies have remained relatively constant over the past ten years. However, rates of late prenatal care have shown a troubling increase, and the percentage of Medicaid enrollees who smoke during their pregnancy has increased after dropping off in 2007.

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[2] Partnership for Solutions, Chronic Conditions: Making the Case for Ongoing Care. September 2004 Update.
[3] Ibid
[4] OREGON HEALTH PLAN*, Tobacco Cessation Services: 2011 Survey of Fully Capitated Health Plans and Dental Care Organizations,* May 2011.
[5] Ibid.
[6] Ibid.
[7] Portland Pulse, from 2007 Oregon DHS data, see: http://www.portlandpulse.org/node/37

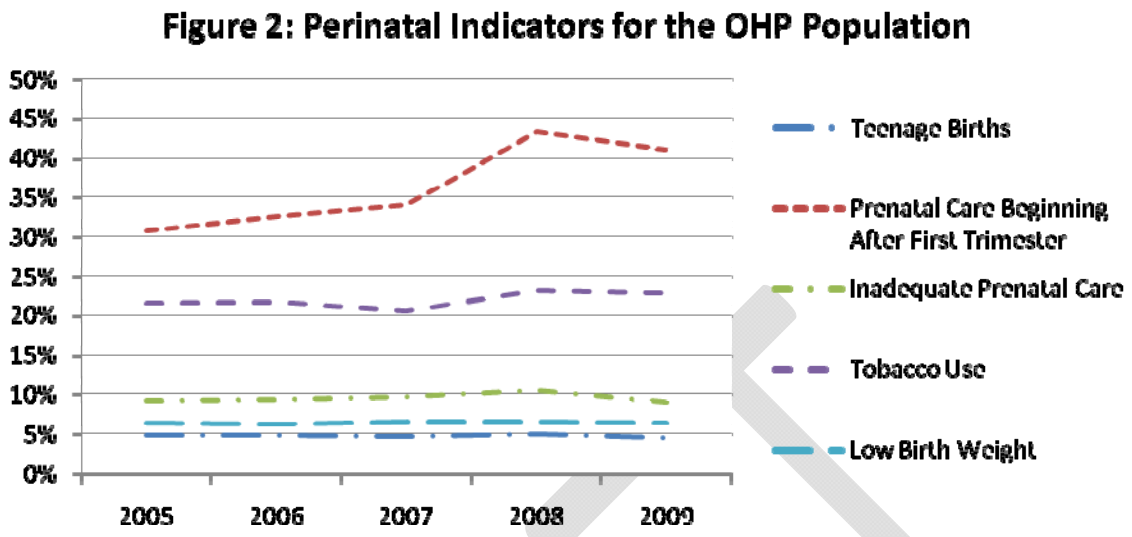

Figure 2: Oregon Vital Statistics Annual Reports 2005-2009

Figure 3 below shows the variation across the state when looking at the prevalence of chronic conditions among current OHP enrollees based on diagnosis codes. The statewide bar shows the average across all seven regions for each of the seven chronic conditions. The regions are defined as follows:

- Region 1: Clatsop, Columbia, Tillamook, Lincoln
- Region 2: Coos, Curry
- Region 3: Benton, Clackamas, Linn, Marion, Multnomah, Polk, Washington, Yamhill
- Region 4: Douglas, Jackson, Josephine, Lane
- Region 5: Crook, Deschutes, Gilliam, Grant, Hood River, Jefferson, Morrow, Sherman, Wasco, Wheeler
- Region 6: Baker, Umatilla, Union, Wallowa
- Region 7: Klamath, Lake, Henry, Malheur

In many instances, there are large disparities across regions. For example, Region 2's population has a diabetes prevalence rate that exceeds the statewide average by more than 30 percent and exceeds the Region 5 prevalence rate by 42 percent. Similarly, Region 2's population has an asthma prevalence rate that exceeds the statewide average by 14 percent and the Region 6 rate by 25 percent.

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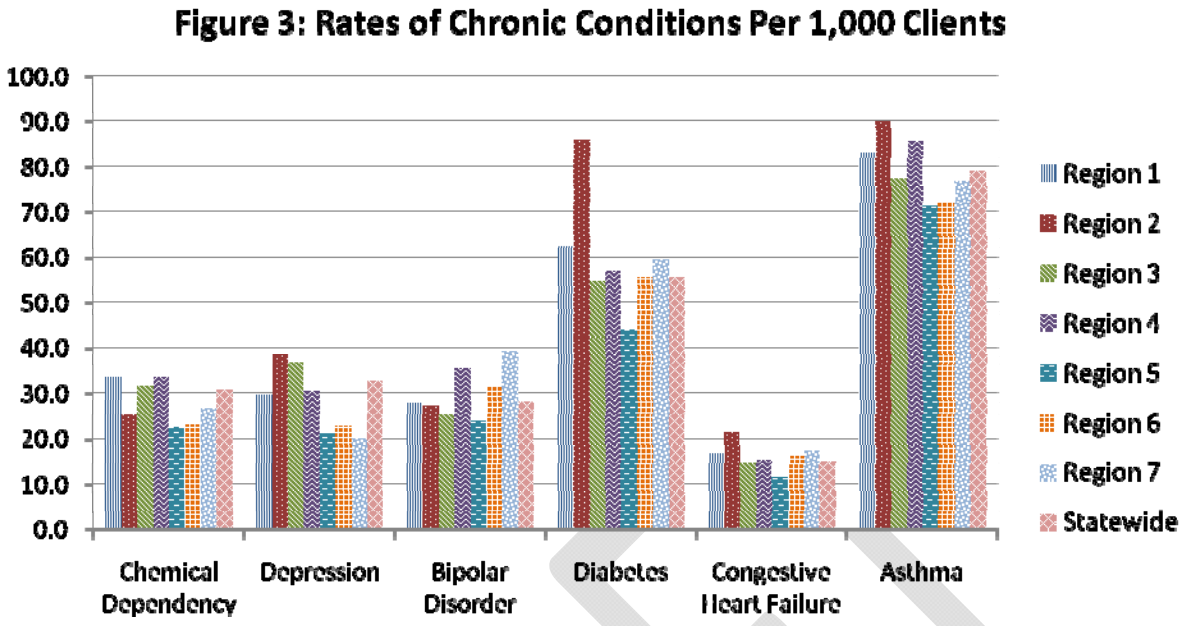


Figure 3: Oregon Health Authority Division of Medical Assistance Programs 8/15/2011.

Figure 4 below illustrates the overweight/obesity trend in Oregon and nationally. The lower portion of each stack represents the percent of the population considered "obese" according to their body mass index (BMI). The total stack represents the percentage of the population considered "overweight or obese". While the percentage of the Oregon population considered "overweight or obese" has stayed relatively stable from 2002-2009, the portion that are classified as "obese" has grown. While overall rates of obesity in Oregon are below national levels, this is a troubling trend, as obesity is one of the most important risk factors for developing diabetes, as well as numerous other chronic conditions and certain types of cancer.

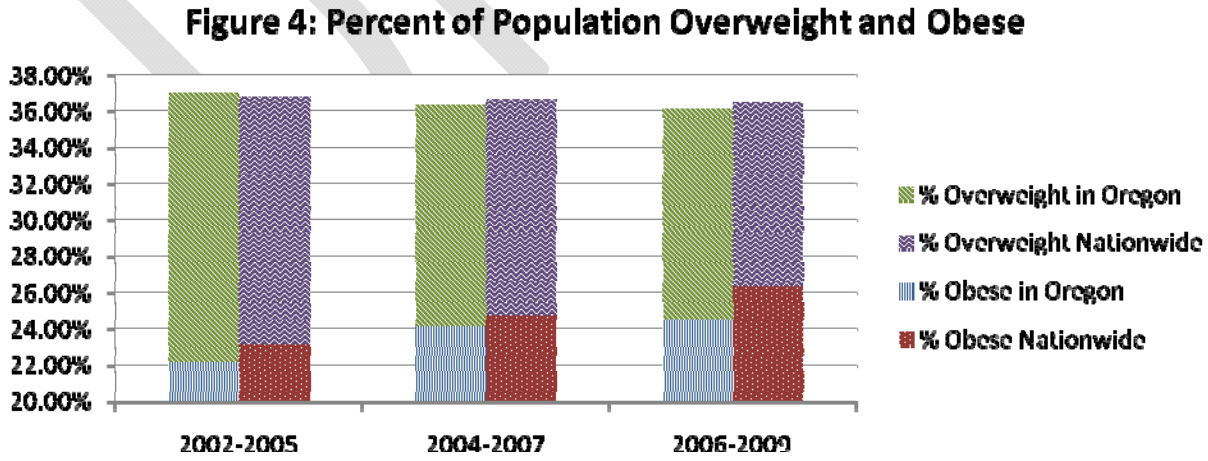


Figure 4: The lower stacks represent the percentage of the population classified as "obese". The total stacks represent the percentage of the population considered "overweight". The data comes from the Behavioral Risk Factor Surveillance System, accessed 12/2011.

Racial and Ethnic Disparities

In addition to overall rates of chronic disease and utilization of preventive services, it is important to look at disparities among racial and ethnic groups. A 2008 study by the Oregon Division of Medical Assistance compared racial and ethnic disparities in Oregon and in the Oregon Health Plan and found that disparities exist but vary by race/ethnic group.[8] The prevalence of chronic disease is worse among certain minority groups compared to whites. For Oregon Health Plan clients, asthma prevalence was higher for American Indians and Alaska Natives than for any other group – and other minority groups' prevalence was lower than whites'. For Oregon Health Plan clients, all minority groups had a higher prevalence of diabetes, except for African Americans, where the prevalence was the same as for whites.

In its 2011 "State of Equity Report," the Department of Human Services and the Oregon Health Authority identified two disparities in key performance measures across race and ethnicity. For the first measure, the utilization rate of preventative services for children from birth to 10 years of age covered by the Oregon Health Plan, a higher rate is favorable. When comparing across the benchmark of non-Hispanic whites, the chart shows Native Americans utilizing preventative services at a rate of less than 75% of the utilization seen in the white population.

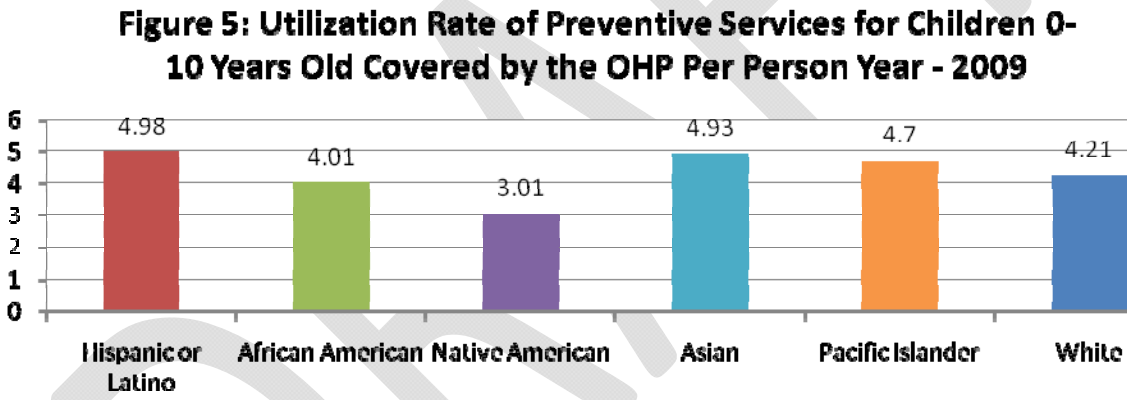


Figure 5: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011. Rates reflect the number of preventive services provided per person year.

In the second measure, the rate of ambulatory care sensitive condition hospitalizations of OHP clients, a lower rate is more favorable. Again, when comparing rates to the benchmark of non-Hispanic whites, the Native American population showcases less positive measures. High rates of hospitalization for ambulatory care sensitive conditions indicate that a condition is not being properly managed. These two disparities together highlight a population in which there is a lack of health care needs being met and indicate a need for outreach and interventions targeted to specific groups.

[8] Division of Medical Assistance Programs and the Public Health Division, "Oregon Department of Human Services' Efforts to Reduce Racial and Ethnic Health Care Disparities." May 23, 2008.

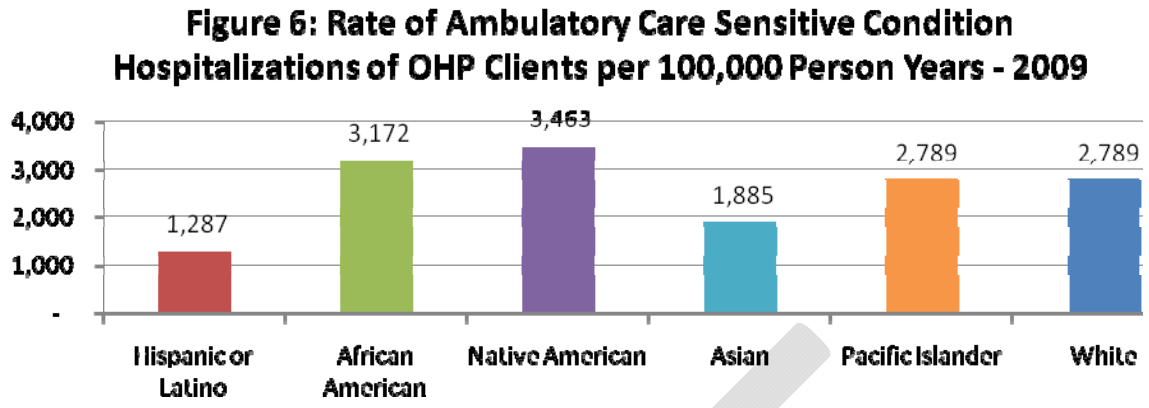
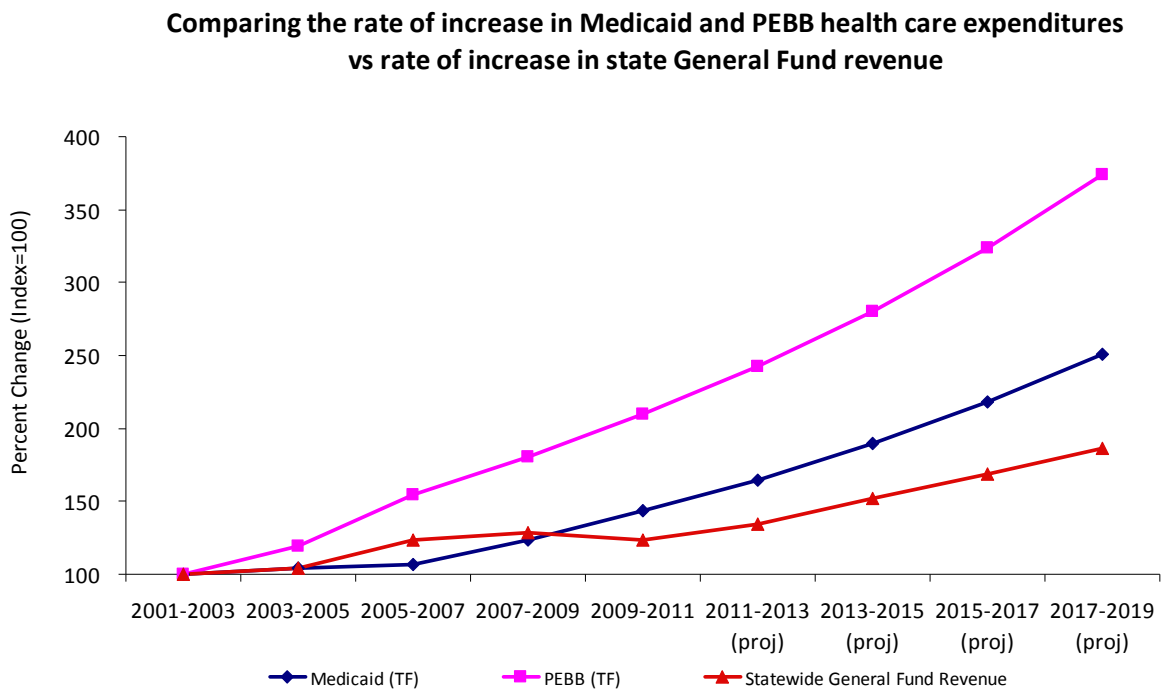


Figure 6: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011.

Unsustainable Cost Growth

While the rate of cost growth in the Medicaid program was effectively controlled in the early 2000s, the rate of growth has increased significantly and now far exceeds the current and projected rate of increase in state General Fund revenue (see Figure below). This trend is clearly unsustainable.



3. Opportunities for Achieving the Triple Aim: Improving Health, Improving Health Care and Reducing Cost

Financial Projections for Greater System Efficiency and Value

Current State

For the year ending June 30, 2013, total Oregon Medicaid payments are expected to approach $3.2 billion. Oregon's Medicaid enrollment has been growing in recent years and the base cost for services has increased historically and is expected to continue to do so. Inflationary factors include higher wages for care providers, changes in medical practice, and the introduction of new treatment protocols and new drugs and technology.

Based upon projected enrollment growth and anticipated cost inflation, total Medicaid expenditures may grow to as much as $11.7 billion in the FY 2017/2019 biennium with over 950,000 individuals enrolled in the program. This figure includes about 250,000 newly-eligible under federal health reform expansion provisions that take effect in 2014.

HB 3650 directs OHA to "prepare financial models and analyses to demonstrate the feasibility of a coordinated care organization being able to realize health care cost savings." OHA contracted with Health Management Associates to conduct this analysis.

Estimates of Health Transformation Savings provided by Health Management Associates

The HMA analysis projects potential savings in six areas:

- Improved management of the population
- Integration of Physical and Mental Health
- Implementation of the Mental Health Preferred Drug List
- Increased Payment Recovery Efforts
- Patient Centered Primary Care Homes
- Administrative Savings from MCO Reductions

Improve to a well-managed system of care

In 2011, a report by Milliman for the Portland area Oregon Health Leadership Council projected savings for a well-managed Medicaid sub-population (TANF) between $118 million and $141 million statewide. According to Milliman, well-managed status reflects attainment of utilization at defined levels equal to optimal benchmarks. Savings reflect the difference between existing service levels and those benchmarks. HMA projected those findings to the entire Medicaid population by extending Milliman projections to the additional Medicaid populations: aged, blind and disabled and the expansion

population. HMA considers these projections conservative because the complexity and level of chronic disease in these groups is higher and generally yields higher savings.

HMA states that the overall integration of care and payment mechanisms would reduce costs primarily on the Medicare side for dually eligible individuals. Based upon a study by the Lewin Group and in conjunction with the report from Milliman, they have estimated this rate at 8.5%. These savings come primarily from Medicare expenditures and a shared savings arrangement with Medicare is essential to obtaining a benefit to the State.

Integration of Physical and Mental Health

A key strategy in Oregon's health system transformation efforts includes the integration of mental health and physical health. A study of integration savings projected results as high as 20% to 40%; however, HMA assumed a lower figure of 10 to 20% given the extent of other savings already applied in Oregon. This includes both the integration of physical health with certain mental health settings as well as the addition of mental health with physical health settings. Further, while HMA did not estimate the benefit of integrating dental health into the overall system, increased coordination should also reduce costs and increase the quality of the consumer's experience.

Implementation of Mental Health Preferred Drug List

This strategy will require legislative approval, so no savings are projected for year one. Clear evidence exists to demonstrate savings while maintaining the same level of treatment outcomes.

Increased Payment Recovery Efforts

CCOs will audit claims to review Medicaid coverage criteria, inappropriate coding assignments, medical necessity, third party liability, coordination of benefits and other targeted areas, and recoup overpayments.

Patient Centered Primary Care Medical Homes

The statewide implementation of the patient-centered primary care home model can further reduce costs. Early implementation of similar models has been shown to reduce total expenditures by up to 7%. By further enhancing the abilities of these homes through connections to specialty care and improving care transitions between levels of care, we believe you can go beyond well managed.

Administrative Savings from MCO Reductions

CCOs will be larger and more comprehensive than existing MCOs and MHOs. Consequently, economies of scale are available from the consolidation and redesign of current administrative functions.

Electronic Health Records and Health Information Exchange

While not included in the table below, the savings from electronic connectivity and reduction in duplicate testing should be noted. Witter & Associates, LLC, estimate avoided services savings at $16 million a year from the widespread adoption and use of health information exchange (HIE). While implementation of statewide HIE is projected to take four to five years, the resultant savings over time

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are substantial. These estimates are not net of provider and health system implementation costs. However, the federal investment in provider incentive payments is providing considerable financial support for these efforts. Additionally, we believe that the savings would be measurable if the costs of implementation could be shared across other payers.

HMA Estimates of Achievable Medicaid Savings Due to Health System Transformation
(each column represents expenditures and savings for that period only)

LOW SAVINGS – Total Funds	**7/12 to 6/13**	**7/13 to 6/15**	**7/15 to 6/17**	**7/17 to 6/19**
Average Enrolled	672,430	733,522	887,750	955,475
Projected Expenditures	**$3,178,000,000**	**$7,439,550,000**	**$10,018,650,000**	**$11,680,350,000**
Improve to "Well Managed"	($43,700,000)	($311,050,000)	($972,900,000)	($1,282,700,000)
Integration of Physical and Mental Health	($31,300,000)	($285,100,000)	($678,400,000)	($1,039,800,000)
Mental Health Preferred Drug List	$0	($16,000,000)	($27,000,000)	($53,100,000)
RAC and Other Audits	($62,700,000)	($142,600,000)	($180,900,000)	($208,000,000)
Patient Centered Primary Care Homes	($11,000,000)	($99,800,000)	($237,500,000)	($363,900,000)
Admin Savings from MCO Reductions	($6,300,000)	($14,300,000)	($18,100,000)	($20,800,000)
Savings from Redesign	**($155,000,000)**	**($868,850,000)**	**($2,114,800,000)**	**($2,968,300,000)**
	$3,023,000,000	**$6,570,700,000**	**$7,903,850,000**	**$8,712,050,000**
	-4.9%	-11.7%	-21.1%	-25.4%

HIGH SAVINGS – Total Funds	**7/12 to 6/13**	**7/13 to 6/15**	**7/15 to 6/17**	**7/17 to 6/19**
Average Enrolled	672,430	733,522	887,750	955,475
Projected Expenditures	**$3,178,000,000**	**$7,439,550,000**	**$10,018,650,000**	**$11,680,350,000**
Improve to "Well Managed"	($65,500,000)	($401,050,000)	($1,113,400,000)	($1,603,850,000)
Integration of Physical and Mental Health	($124,500,000)	($703,900,000)	($1,781,100,000)	($2,015,300,000)
Mental Health Preferred Drug List	$0	($16,000,000)	($27,000,000)	($51,800,000)
RAC and Other Audits	($62,300,000)	($140,800,000)	($178,100,000)	($201,500,000)
Patient Centered Primary Care Homes	($43,600,000)	($246,300,000)	($623,400,000)	($705,400,000)
Admin Savings from MCO Reductions	($12,500,000)	($28,200,000)	($35,600,000)	($40,300,000)
Savings from Redesign	**($308,400,000)**	**($1,536,250,000)**	**($3,758,600,000)**	**($4,618,150,000)**
	$2,869,600,000	**$5,903,300,000**	**$6,260,050,000**	**$7,062,200,000**
	-9.7%	-20.6%	-37.5%	-39.5%

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4. Coordinated Care Organization (CCO) Certification Process

Pending direction and approval by the Legislature during the February 2012 session, the Oregon Health Authority will begin a non-competitive Request for Applications (RFA) procurement process that specifies the criteria organizations must meet to be certified as a CCO. Prospective CCOs will asked to submit applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650, including being prepared to enroll all eligible persons within the CCO's proposed service area.

In early spring 2012, OHA will promulgate administrative rules describing the CCO application process and criteria. Once the criteria have been finalized, the application process for prospective CCOs is planned as follows: (see Section 9 of this document for a timeline):

- CCO criteria will be posted online by OHA
- OHA will release a "Request for CCO Application"
- CCO applicants will submit letters of intent to OHA
- CCO applicants will submit applications to OHA
- OHA will evaluate CCO applications
- OHA will certify CCOs
- CMS will collaborate with OHA evaluation of applications and certification of CCOs, or may follow with a separate certification with respect to individuals who are dually eligible

Because CCOs will be responsible for integrating and coordinating care for individuals who are dually eligible for Medicare and Medicaid, the application will include the relevant Medicare plan requirements that will build on the existing CMS Medicare Advantage application process, streamlining the process for any plans that have previously submitted Medicare Advantage applications. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

Evaluation of CCO applications will account for the developmental nature of the CCO system. CCOs, OHA and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by HB 3650. In all cases, CCOs will be expected to have plans in place for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by HB 3650.

Alternative Dispute Resolution

- ***Section 8(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.***
- ***Section 8 (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.***
- ***Section 8 (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for***

services that are available through a coordinated care organization either directly or by contract.

- ***Section 8 (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.***

Regarding the creation of CCOs, requires the development of a dispute resolution process. If a health care entity (HCE) is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization, a process will be available to those parties that includes the use of an independent third party arbitrator. A more complete description of the proposed process is provided in Appendix C. A summary of the primary objectives and components of the process is provided here.

A dispute resolution process using an arbitrator will follow after a good faith effort between the parties to agree to mutually satisfactory contract terms. If there is a question about whether the HCE is "necessary" for the certification of the CCO, the parties can consult with OHA. If there are technical questions that OHA can assist the parties with concerning the certification process, this consultation will be available. However, the primary goal is for the parties who are necessary to the certification of a CCO to work together to agree upon the terms of a contract. Evidence of good faith negotiations should include at least one face-to-face meeting between the Chief Executive Officer and/or Chief Financial Officer of the HCE and of the organization applying for CCO certification, to discuss the contract offer that has been made and the reasons why the HCE has not accepted the offer. If that process does not result in a contract, either party can request the use of an arbitrator.

This dispute resolution process using an arbitrator applies when (and only when) an HCE is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization. This process is designed to be completed within 60 calendar days. When one party initiates the dispute resolution process, the other party and OHA will receive written notification. The parties will then identify a mutually acceptable arbitrator, who must be familiar with health care issues and HB 3650, and who agrees to follow the dispute resolution process described in Appendix C. In the first 10 days, both parties must send their most reasonable contract offer to each other and the arbitrator, or an explanation of why no contract is desired; in the next 10 days, the parties can file a written explanation for why the offer or refusal to contract is reasonable or unreasonable. The arbitrator has 15 days to review these materials and issue a decision about whether the HCE refusal to contract is reasonable or unreasonable. Having received the decision, the parties have an additional 10 days to resolve their dispute and agree on a contract. At any point in the process, the parties can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

5. Coordinated Care Organization (CCO) Criteria

In order to be certified as a CCO, organizations will be asked to address the criteria outlined in Sections 4 through 13 of HB 3650 and to illustrate how their organization and systems support the Triple Aim. OHPB recommendations for CCO criteria, outlined below, were developed from a combination of stakeholder workgroup input, public comment, OHPB-sponsored community meetings held throughout the state, and public and invited testimony at Board meetings, as well as Board deliberations. Appendix D contains a consolidated list of the proposed CCO criteria along with minimum and transformational expectations for each criterion.

Governance and organizational relationships

- ***Section 4(1)(o)(A-C): (o) Each CCO has a governance structure that includes: (A) a majority interest consisting of persons that share 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 of the community.***
- ***Section 4(1)(i) Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met.***
- ***Section 4(2) The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.***
- ***Section 4(3) On or before July 1, 2014, each CCO will have a formal contractual relationship with any DCO in its service area.***
- ***Section 24(1-4): CCOs shall have agreements in place with publicly funded providers to allow payment for point of contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning, and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.***

<u>Governing Board</u>

CCO organizational structures will vary to meet the needs of the communities they will serve. There is no single governance solution, and there is risk in being too prescriptive beyond the statutory definition of a CCO governing board. Instead, governing board criteria will support a sustainable, successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim.

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As part of the certification process, a CCO should articulate:

- How individuals bearing financial risk for the organization make up the governing board's majority interest,
- How the governing board includes members representing major components of the health care delivery system,
- How consumers will be represented in the portion of the governing board that is not composed of those with financial risk in the organization; and
- How the governing board makeup reflects the community needs and supports the goals of health care transformation.
- What are the criteria and process for selecting members on the governing board, CAC and any other councils or committees of the governing board?

Community Advisory Council (CAC)

HB 3650 requires that each CCO convene a Community Advisory Council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of membership. It further requires that the CAC meets regularly to ensure that the health care needs of the consumers and the community are being met.

At least one member from the Community Advisory Council (chair or co-chairs) will also serve on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations. There must be transparency and accountability for the governing board's consideration and decision making regarding recommendations from the CAC.

Clinical Advisory Panel

Potential CCOs will establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices. Representation on the governing board should be required, as with the Community Advisory Council.

In addition, the CCO will need to address the following in its application:

- How will the CAC and any other councils or committees of the governing board support and augment the effectiveness of governing board decision-making?
- What are the structures initially and over time that will support meaningful engagement and participation of CAC members, and how will they address barriers to participation?

Partnerships

HB 3650 encourages partnerships between CCOs and local mental health authorities and county governments in order to take advantage of and support the critical safety net services available through county health departments and other publicly supported programs. Unless it can be shown why such arrangements would not be feasible, HB 3650 requires CCOs to have agreements with the local mental health authority regarding maintenance of the mental health safety net and community mental health needs of CCOs members, and with county health departments and other publicly funded providers for

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payment for certain point-of-contact services. OHPB directs OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.

Community Needs Assessment

CCOs should partner with their local public health authority and hospital system to develop a shared community needs assessment that includes a focus on health disparities in the community. The needs assessment will be transparent and public in both process and result. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, OHA should work with communities and other relevant bodies such as the OHA Office of Equity and Inclusion and the Health Information Technology Oversight Council (HITOC) to create as much standardization as possible in the components of the assessment and data collection so that CCO service areas can be meaningfully compared, recognizing that there will be some differences due to unique geographic settings and community circumstances.

In developing a needs assessment, CCOs should meaningfully and systematically engage representatives of critical populations and community stakeholders to create a plan for addressing community need that builds on community resources and skills and emphasizes innovation. OHA will define the minimum parameters of the community needs assessment with the expectation that CCOs will expand those as necessary to identify the needs of the diverse communities in the CCO service area. The Public Health Institute's *"Advancing the State of the Art in Community Benefit"* offers a set of principles that provide guidance for this work[9]:

- Emphasis on disproportionate unmet, health-related need
- Emphasis on primary prevention
- Building a seamless continuum of care
- Building community capacity
- Emphasis on collaborative governance of community benefit

Patient Rights and Responsibilities, Engagement, and Choice

- ***Section 4(1)(a) Each member of the CCO receives integrated person-centered care and services designed to provide choice, independence and dignity.***
- ***Section 4(1)(h) Each CCO complies with safeguard for members as described in Section 8, Consumer and Provider Protections of HB 3650:***
    - ***Section 8(1) The Oregon Health Authority shall adopt by rule safeguards for members enrolled in coordinated care organizations that protect against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, each member:***

    (a) Must be encouraged to be an active partner in directing the member's health care and services and not a passive recipient of care.

[9] Public Health Institute, *Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability,* November, 2004.

(b) Must be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system.

(c) Must have access to advocates, including qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers who are part of the member's care team to provide assistance that is culturally and linguistically appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services.

(d) Shall be encouraged within all aspects of the integrated and coordinated health care delivery system to use wellness and prevention resources and to make healthy lifestyle choices.

(e) Shall be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs as a whole person.

- ***Section 4(1)(k) Members have a choice of providers within the CCOs network and that providers participating in the CCO: (A) work together to develop best practices for care and delivery to reduce waste and improve health and well-being of members, (B) are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history, (C) emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication, (D) are permitted to participate in networks of multiple CCOs, (E) include providers of specialty care, (F) are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards, (G) work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members.***

Members enrolled in CCOs should be actively engaged partners in the design and, where applicable, implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices should be reflected in the development of treatment plans and member dignity will be respected. Under this definition, members will be better positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against underutilization of services and inappropriate denials of services.

In addition to any other consumer rights and responsibilities established by law, CCOs should demonstrate how they will:

- Determine the best patient engagement approaches and barriers by engaging the community and via the community needs assessment.
- Encourage members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members.
- Engage members in culturally appropriate ways.
- Educate members on how to navigate the coordinated care approach.

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- Encourage members to use wellness and prevention resources and to make healthy lifestyle choices.
- Meaningfully engage the Community Advisory Council to monitor patient engagement and activation.

Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements

- ***Section 4(1)(b) Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings.***
- ***Section 4(1)(c) Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible.***
- ***Section 4(1)(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.***
- ***Section 4(1)(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health interpreters, community health workers, and personal health navigators who meet competency standards developed by the Authority.***
- ***Section 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.***

- ***Section 4(1)(j) Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.***
- ***Sec 4(1)(k)(G) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Section 4(1)(n) Each CCO participates in the learning collaborative described in ORS 442.210(3).Section 6(2) Each CCO shall implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology***.
- ***Section 6(3) Standards established by the authority for the utilization of patient centered primary care homes by CCOs may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.***

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- ***Sec 20(4) 'Community health worker' means an individual who:***
  - ***c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;***
  - ***d) Assists members of the community to improve their health and increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness;***
  - ***e) Provides health education and information that is culturally appropriate to the individuals being served;***

Transformation relies on ensuring that CCO members have access to high quality care. This will be accomplished by the CCO through a provider network capable of meeting health systems transformation objectives. The following criteria focus on elements of a transformed delivery system critical to improving the member's experience of care as a partner in care rather than as a passive recipient of care.

Patient-Centered Primary Care Homes

Integral to transformation is the patient-centered primary care home (PCPCH), as currently defined by Oregon's statewide standards. These standards were developed through a public process as directed by HB 2009 to advance the Triple Aim goals of better health, better care, lower costs by focusing on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, a patient and family-centered approach to all aspects of care, and an emphasis on whole-person care in order to address a patient's (and family's) physical and behavioral health care needs.

Building on this work, CCOs will demonstrate how they will use PCPCH capacity to achieve the goals of health system transformation including:

- How the CCO will partner with and/or implement a network of patient-centered primary care homes as defined by Oregon's standards to the maximum extent feasible, as required by HB 3650.
- How the CCOs will require their other contracting health and services providers to communicate and coordinate care with the PCPCH in a timely manner using electronic health information technology, where available, as required by HB 3650.
- How the CCO will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650, and members' experience of care and outcomes are improved. Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation.
- How the CCO's patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and services, as described in the bill, and that members are fully informed partners in transitioning to this model of care.
- How members will be informed about access to non-traditional providers, if available through the CCO. As described in HB 3650, these providers may include personal health navigators, peer

wellness specialists where appropriate, and community health workers who, as part of the care team, provide culturally and linguistically appropriate assistance to members to access needed services and participate fully in all in processes of care.

Care Coordination

Care coordination is a key activity of health system transformation. Without it, the health system suffers costly duplication of services, conflicting care recommendations, medication errors, and member dissatisfaction, which contribute to poorer health outcomes and unnecessary increases in medical costs.

CCOs should demonstrate the following elements of care coordination in their applications for certification:

- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and a standardized follow-up approach in the absence of full health information technology capabilities.
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services.
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication.

CCO applicants should be able to describe the evidence-based or innovative strategies they will use within their delivery system networks to ensure coordinated care, especially for members with intensive care coordination needs, as follows.

- *Assignment of responsibility and accountability:* CCOs must demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions, as required by HB 3650.
- *Individual care plans:* As required by HB 3650, CCOs will use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.
- *Communication*: CCOs will demonstrate that providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having electronic health record (her) capabilities, etc.).

Effective transformation requires the development of a coordinated and integrated delivery system provider network that demonstrates communication, collaboration and shared decision making across the various providers and care settings. OHPB understands this work will occur over time. As each CCO develops, it will be expected to demonstrate:

- How it will ensure a network of providers to serve members' health care and service needs, meet access-to-care standards, and allow for appropriate choice for members as required by HB

3650. The bill also requires that services and supports should be geographically as close to where members reside as possible and, to the extent necessary, offered in nontraditional settings that are accessible to families, diverse communities, and underserved populations.

- How it will build on existing provider networks and transform them into a cohesive network of providers.
- How it will work to develop formal relationships with providers, community health partners, and state and local government support services in its service area(s), as required by HB 3650, and how it will participate in the development of coordination agreements between those groups.

Care Integration

- *Mental Health and Chemical Dependency Treatment:* Outpatient mental health and chemical dependency treatment will be integrated in the person-centered care model and delivered through and coordinated with physical health care services by the CCO. HB 3650 requires OHA to continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a CCO but no later than July 1, 2013.
- *Oral Health:* By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside. Shared financial accountability will encourage aligned financial incentives for cost-effectiveness and to discourage cost shifting.
- *Hospital and Specialty Services:* Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes and that specify: processes for requesting hospital admission or specialty services; performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care.

Quality Assurance and Improvement

It is a continued goal of the OHA to require contracted Medicaid providers to meet established standards for quality assessment and improvement. As part of the certification process, CCOs will describe planned or established mechanisms for:

- A complaint/grievance and appeals resolution process, including how that process will be for communicated to members and providers;
- Establishing and supporting an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops;
- Participating in data collection and/or reporting for OHA accountability metrics;
- Implementing an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.

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Health Equity and Eliminating Health Disparities

- ***Section 2(2). The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.***
- ***Section 2(3)(b). The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including progress toward eliminating health disparities.***
- ***Sec 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.***
- ***Section 4(1)(k)(G). [Providers participating in a Coordinated Care Organization] work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Sec 19(1)(L) The authority shall: Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).***
- ***Sec 30(1)(a) Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:***
  (a) Demographics, including race and ethnicity.
  (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.

Health equity means reaching the highest possible level of health for all people. Historically, health inequities result from health, economic, and social policies that have disadvantaged communities. These disadvantages result in tragic health consequences for vulnerable populations and increased health care costs to the entire system, costs which are borne by taxpayers, employers, workers, and the uninsured. CCOs will ensure that everyone is valued and health improvement strategies are tailored to meet the individual needs of all members, with the ultimate goal of eliminating health disparities.

HB 3650 encourages CCOs and their associated providers to work together to develop best practices of culturally appropriate care and services delivery to reduce health disparities and improve health and well-being of members. Through their community needs assessment, CCOs will be expected to identify

health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, or other factors in their service areas. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, the OHA Office of Equity and Inclusion should assist in identifying standard components (e.g., workforce) that CCOs should address in the assessment to ensure that all CCOs have a strong and comparable set of baseline data on health disparities.

CCOs will be expected to collect or maintain race, ethnicity, and primary language for all members on an ongoing basis in accordance with standards jointly established by OHA and Oregon's Department of Human Services. CCOs can then track and report on any quality measure by these demographic factors and will be expected to develop, implement, and evaluate strategies to improve health equity among members.

Payment Methodologies that Support the Triple Aim

- ***Section 5(1). The OHA shall encourage CCOs to use alternative payment methodologies that: (a) reimburse providers on the basis of health outcomes and quality instead of the volume of care; (b) hold organizations and providers responsible for the efficient delivery of quality care; (c) reward good performance; (d) limit increases in medical costs; (e) use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination.***

To encourage improved quality and efficiency in the delivery of services, it will be necessary for CCOs to move from a predominantly fee-for-service system to alternative payment methods that base reimbursement on the quality rather than quantity of services provided. CCOs will be expected to demonstrate how their payment methodologies promote the following principles:

- Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;
- Hold organizations and providers accountable for the efficient delivery of quality care;
- Limit increases in medical costs;
- Promote prevention, early identification and intervention of conditions that lead to chronic illnesses;
- Provide comprehensive coordination or create shared responsibility across provider types and levels of care, using such delivery systems such as patient-centered primary care homes; and
- Utilize evidence-based practices and health information technology to improve health and health care.

While CCOs will have flexibility in the payment methodologies they choose to use, CCOs are encouraged to rely on previously developed and tested payment approaches where available. Efforts to create incentives for evidence-based and best practices will be expected to increase health care quality and patient safety and to result in more efficient use of health care services. To ensure successful transition to new payment methods, it will be necessary for CCOs to build network capacity and to help restructure systems and workflows to be able to respond effectively to new payment incentives.

Health Information Technology

- ***Section 4(1)(g) Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent possible.***

OHPB requested that the Health Information Technology Oversight Council (HITOC) provide advice on appropriate health information technology (HIT) certification criteria for CCOs. In order to ensure that coordinated care delivery is enabled through the availability of electronic information to all participants, HITOC suggests that CCOs will need to develop the HIT capabilities described below. CCOs will span different provider types across the continuum of care and different geographic regions across the state, each of which is at different stages of HIT adoption and maturity. The proposed approach for achieving advanced HIT capability is to meet providers and communities where they are and require improvement over time. CCOs will ultimately need to achieve minimum standards in foundational areas of HIT use (electronic health records, health information exchange) and to develop their own goals for transformational areas of HIT use (analytics, quality reporting, patient engagement, and other health IT).

Electronic Health Records Systems (EHRs)

CCOs should facilitate providers' adoption and meaningful use of EHRs. EHRs are a foundational component of care coordination because they enable providers to capture clinical information in a format that can be used to improve care, control costs, and more easily share information with patients and other providers. In order to achieve advanced EHR adoption and meaningful use, CCOs will be expected to:

- Identify EHR adoption rates; rates may be divided by provider type and/or geographic region.
- Develop and implement strategies to increase adoption rates of certified EHRs.
- Consider establishing minimum requirements for EHR adoption over time. Requirements may vary by region or provider type;

Health Information Exchange (HIE)

CCOs will facilitate electronic health information exchange in a way that allows all providers to exchange a patient's health information with any other provider in that CCO. HIE is a foundational component of care coordination because it enables providers to access pertinent health information when and where it is needed to provide the best care possible and to avoid performing duplicative services. CCOs will be expected to ensure that every provider is:

- **Either** registered with a statewide or local Direct-enabled Health Information Service Provider (HISP)
    - Direct is a way for one provider to send secure information directly to another provider without using sophisticated information systems. Direct secure messaging will be available to all providers as a statewide service, and while EHR vendors will continue to develop products with increasingly advanced Direct functionality, using Direct secure messaging does not require an EHR system. Registration will ensure the proper identification of

participants and secure routing of health care messages, and the e-mail address provided with Direct secure messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time.

- **Or** is a member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

CCOs should also consider establishing minimum requirements for HIE, including rates of e-prescribing and electronic lab orders, over time.

CCOs will leverage HIT tools to transform from a volume-based to a value-based delivery system. In order to do so, CCOs should initially identify their current capacity and develop and implement a plan for improvement (including goals/milestones, etc.) in the following areas:

- Analytics (to assess provider performance, effectiveness and cost-efficiency of treatment, etc.)
- Quality Reporting (to facilitate quality improvement within the CCO as well as to report the data on quality of care that will allow the OHA to monitor the performance of the CCO)
- Patient Engagement through HIT (using existing tools such as e-mail, etc.)
- Other HIT (telehealth, mobile devices, etc.)

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6. Global Budget Methodology

- **Section 13(2)(b) Using a meaningful public process, the Oregon Health Authority shall develop…a global budgeting process for determining payments to CCOs and for revising required outcomes with any changes to global budgets.**

CCO global budgets are designed to cover the broadest range of funded services for the most beneficiaries possible. The construction of global budgets start with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. Global budgets should include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This inclusive approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope. The global budget approach also allows CCOs maximum flexibility to dedicate resources towards the most efficient forms of care.

Once CCOs are phased in, quality incentives will be incorporated into the global budget methodology to reward CCOs for improving health outcomes in order to increasingly pay for quality of care rather than quantity of care.

CCO global budgets will be comprised of two major components: capitated and non-capitated. The capitated portion will include funding for all services that can be disbursed to CCOs in a prospective per member per month payment. Initially, the capitated portion should include all services currently provided by physical health, mental health, and, by 2014 if not before, dental care organizations. The non-capitated portion of the global budget calculation will be for programs and services that are currently provided outside of managed care. The CCO will receive payment and be accountable for the provision of those services.

This approach provides a flexible format that recognizes that not all current Medicaid funding lends itself neatly to a per member per month calculation. As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

Primary Components of the CCO global budgets and shared accountability arrangements:

Medicaid Services currently capitated under managed care	**Medicaid services <u>not</u> currently capitated under managed care**	**Exclusions from CCO Global Budgets**
Physical health services	Physical health services	Long term care services
+ Mental health services	+ Mental health services	+ Mental health drugs
+ Oral health services (if included)	+ Medicaid funded public health services	+ Services postponed from inclusion
Per member per month capitated payment	*Non-capitated portion; payment basis may vary*	*Shared accountability for outcomes and costs may be possible.*

CCO Global Budget

Populations Included in Global Budget Calculations

With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. An overview of the eligible CCO populations and their current managed care enrollment can be found in Appendix E. Approximately, 78 percent of people who are eligible for Medicaid are enrolled in a capitated physical health plan, 88 percent in a mental health organization, and 90 percent in a dental care organization.[10] HB 3650 directs OHA to enroll as many of the remaining eligible individuals (who are currently in fee-for-service) into a CCO as possible. Section 28 of HB 3650 specifically exempts American Indians, Alaska Natives and related groups from mandatory enrollment in CCOs.

Service/Program Inclusion and Alignment

One of the primary goals of the global budget concept is to allow CCOs flexibility to invest in care that may decrease costs and achieve better outcomes. The more programs, services and funding streams that are included in CCO global budgets, the more flexibility and room for innovation exists for CCOs to provide comprehensive, person-centered care. In addition, leaving necessary care outside of the global budget creates conflicting incentives where the action of payers outside of the CCO, who have little reason to contribute to CCO efficiencies, may have undue impact on costs and outcomes within the CCO.

In considering which Medicaid funding streams should be included in the global budget, the budget will start with the presumption that all Medicaid dollars are in the global budget (with the exception of the services explicitly excluded by HB 3650.) See Appendix F for a list of the services funded by Medicaid funds. Without exception, funding and responsibility for all current services provided by managed physical and mental health organizations as well as non-emergent transportation will be included in each CCO's global budget. The services that are currently capitated under physical and mental health organizations account for approximately 80 percent of Oregon's non-long-term care Medicaid expenditures. Non-emergent transportation represents another two percent of expenditures.

Currently, five percent of Oregon's non-long-term care Medicaid expenditures are associated with payments for dental care through DCOs. Dental expenditures will be included in global budgets based on individual CCO determination, as HB 3650 allows until July 1, 2014 to incorporate these services.

With respect to the remaining 13 percent of non-long-term care Medicaid expenditures, OHPB believes exceptions to service or program inclusion in the global budgets should be minimal. However, consideration could be given to CCO requests to postpone inclusion of one or more services or programs on the grounds that their inclusion would negatively impact health outcomes by reducing available funding, access or quality. CCOs are strongly encouraged to develop strategic partnerships within their community in order to successfully manage comprehensive global budgets.

[10] Citizen Alien Waived Emergent Medical (CAWEM) beneficiaries and individuals who are partially dual eligible for Medicaid and Medicare—including Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB)—are not included in this calculation.

In the case of services that are postponed or excluded from CCO global budgets, it is anticipated that CCOs will enter into shared accountability arrangements for the cost and health outcomes of these services in order to ensure that incentives are aligned in a manner that facilitates optimal coordination. HB 3650 excludes mental health drugs and long-term care services from CCO global budgets. As described in the Accountability section below, these and other exclusions from CCO global budgets weaken incentives for coordinated care, which must be addressed.

Global Budget Development

The overall global budget strategy will hold CCOs accountable for costs but not enrollment growth. This strategy suggests an overall budgeting process that builds off of the current capitation rate methodology, but also includes a broader array of Medicaid services and/or programs. CCOs' 1st year global budgets will include two Medicaid components:

- A capitated portion that includes the per member per month payments for services currently provided through the OHP physical health plans, mental health organizations and, if included, dental care organizations; and,
- An add-on component to the capitated portion for the remaining Medicaid services or programs not currently included in capitation payments.

Additionally, CCO global budgets will also include Medicare funding to blend with their Medicaid funding to care for individuals eligible for both programs. After the development of an initial baseline of quality and outcome data, OHA will develop a quality incentive component to the global budget methodology to reward CCOs for improved health care outcomes and controlling costs.

<u>Capitated Portion of the Global Budget Methodology</u>

At least initially, the capitated portion CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011-13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the community it serves.

Under this approach, potential CCOs will submit a completed Base Cost Template using internal cost data that is representative of a minimum base population. This will not be a competitive bidding process, but OHA actuaries will review the submission for completeness and soundness in order to establish a base rate. Once a base rate is established, the state actuaries will use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

More specifically, in order to establish rates, OHA will gather estimated costs that utilize the most reliable cost data from potential CCOs in order to produce a base cost while addressing actuarial soundness, CCO viability, and access to appropriate care. This cost data will indicate the lowest rate a CCO can accept in their "base region," based on current population, geographic coverage and benefit package (the "CCO Base Cost Template" referenced above). OHA will use the CCO Base Cost Template as the foundation for the CCO capitation rates. If CCOs propose to operate in geographic areas where they

have little or no experience, state actuaries will use a population-based risk adjustment methodology based on the currently used Chronic Illness and Disability Payment System (CDPS), to develop the rates in these new areas.

It is anticipated that initial CCO global budget amounts be established for one year, but that stakeholders and OHA will explore the possibility of establishing global budgets that could be enacted on a biennial or multi-year basis thereafter. For subsequent years, stakeholders have indicated support for continuing to adjust payments to CCOs based on member risk profiles under the current CDPS process. Stakeholders have encouraged OHA to investigate the possibility of including pharmacy data and expanded demographic data into CDPS.

Pending direction and approval by the Legislature during the February 2012 session, it is expected that OHA carry out the following process for prospective CCOs (see Section 9 of this document for a timeline):

- Finalize CCO definition/scope and process
- Release CCO estimated cost submission process document
- Collect comments on estimated cost submission process document
- Make final changes to estimated cost submission process
- Release of CCO base cost template
- Release Notice of Intent to contract as CCO
- Collect base cost template from prospective CCOs
- Review and certification of CCO rates
- Conduct final review of CCO capitation rates
- Submit CCO capitation rates to CMS
- Submit contracts to CCOs

CCO contractors will provide Notice of Intent to contract as a CCO followed by a submission of base costs to OHA not later than the beginning of May, 2012. OHA's Actuarial Services Unit will be available for technical assistance and work closely with potential CCOs to help them prepare and submit their base cost estimates. If a potential CCO declines to provide a base cost template, OHPB does not recommend certifying a capitation rate for the CCO or issuing the CCO a contract.

The CCOs submitted rates will be reviewed by OHA's actuary and assessed for reasonableness based on documentation that the CCO is capable of:

- Attaining identified efficiencies without endangering its financial solvency
- Providing adequate access to services for its enrollees, and
- Meet all necessary federal standards, including but not limited to explanatory notes detailing planned actions, such as initiatives to increase efficiency.

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OHA's Actuary will assess actuarial soundness at the CCO and region level, and will confer with the CCO regarding any questions or issues that need to be resolved. Additional calculations may be required to ensure that CCO rates in aggregate meet the 2011-13 legislatively approved budget.

Non-capitated or "supplemental" portion of the Global Budget Methodology

As previously stated, the OHPB recommended approach to global budgets starts with the assumption that all Medicaid funding associated with a CCO's enrolled population is included. The non-capitated portion of the global budget calculation will encompass programs and services that are currently provided outside of managed care. The CCO will now receive payment and be accountable for the provision of those services.

However, the Board recognizes that it may not be feasible or optimal to initially wrap all Medicaid services that have been traditionally outside of managed care capitation into a per member per month payment calculation. This may be the case when communities provide the state matching funds for certain Medicaid services. New financing arrangements between the state, CCO, and county will be needed to ensure the ability to match local funds is not compromised. In other cases, there may not be adequate experience to comfortably base a per member per month calculation, at least initially.

As the CCO develops and more experience is gained with the global budget, the breadth of funding incorporated into the capitated portion of the global budgets may expand.

Blended Funding for Individuals who are Dually Eligible for Medicare and Medicaid

In HB 3650, the legislature directed OHA to seek federal waivers and permissions necessary to allow CCOs to provide Medicare and Medicaid services to individuals who are eligible for both programs. Inclusion of dually eligible enrollees in the CCOs and the associated Medicare funding in the global budget is important for a number of reasons. Medicare spending covers the majority of the costs for individuals who are dually eligible, and the vast majority of costs not associated with long-term care. Medicare is the primary payer for dual eligible beneficiaries, and therefore covers the preponderance of medical services. Including Medicare funding in the global budget creates a larger pool of funding to leverage and will allow CCOs to find economies of scope and scale. Including Medicare funding also will provide a significant opportunity to use these funding streams more flexibly and integrate care more effectively. Better coordination of care for Oregon's dually eligible population holds promise for better health and health care for them and lower Medicare and Medicaid spending.

Quality Incentive Payments

CCO global budget payments should be connected to quality metrics for both clinical processes and health outcomes. However, the Board recognizes such an incentive structure will be difficult to initiate in the first year of CCO operation. So initially, metrics will be utilized to ensure adequate CCO performance for all programs or funding streams in the global budget and to create a data baseline. After the initial period, metrics should be used to determine exceptional performers who would qualify for incentive rewards. The Board supports Oregon's discussions with CMS on developing an incentive program as early as possible and is following the progress of the Massachusetts Blue Cross/Blue Shield

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Alternative Quality Contract and other new incentive models such as the Five-Star Quality Rating for Medicare Advantage plans to garner lessons that may be applied to CCO global budget development. The Board has emphasized that any incentive design should include shared savings approaches so that CCOs are not penalized for successfully lowering costs.

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7. Accountability

OHA's Accountability in Supporting the Success of CCOs

OHA will be an active partner in health care transformation and support CCOs by:

- Providing accurate and timely data and feedback to CCOs.
- Implementing and supporting learning collaboratives in partnership with CCOs, as required by HB 3650.
- Identifying and sharing information on evidence-based best practices, emerging best practices and innovative strategies in all areas of health care transformation including patient engagement and activation.
- Providing technical assistance to CCOs to develop and share their own best practice approaches. OHA should develop a system to monitor the development of best practices and the accumulation of evidence supporting new practices or innovations and should then support widespread adoption of the innovations or best practices.
- Reducing and streamlining administrative requirements.

Further, HB 3650 requires that OHA report back to the Legislature regularly on the progress of payment reform and delivery system change. It further directs OHA to publish data on quality, costs and outcomes at the CCO level.

- ***Sec 2(3)(b) The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including:***
    - ***a) The achievement of benchmarks;***
    - ***b) Progress toward eliminating health disparities;***
    - ***c) Results of evaluations;***
    - ***d) Rules adopted;***
    - ***e) Customer satisfaction;***
    - ***f) Use of patient centered primary care homes;***
    - ***g) The involvement of local governments in governance and service delivery; and***
    - ***h) Other developments with respect to coordinated care organizations.***
- ***Section 10(2) The authority shall evaluate on a regular and ongoing basis key quality measures, including health status, experience of care and patient activation, along with key demographic variables including race and ethnicity, for members in each coordinated care organization and for members statewide.***
- ***Section 10(3) Quality measures identified by the authority under this section must be consistent with existing state and national quality measures. The authority shall utilize available data systems for reporting and take actions to eliminate any redundant reporting or reporting of limited value.***
- ***Section 10(4) The authority shall publish the information collected under this section at aggregate levels that do not disclose information otherwise protected by law. The information published must report, by coordinated care organization:***
  (a) Quality measures;
  (b) Costs;

(c) Outcomes; and
(d) Other information, as specified by the contract between the coordinated care organization and the authority, that is necessary for the authority, members and the public to evaluate the value of health services delivered by a coordinated care organization.

CCO Accountability

- ***Section 10(1) The Oregon Health Authority through a public process shall identify objective outcome and quality measures and benchmarks, including measures of outcome and quality for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCO contracts to hold the organizations accountable for performance and customer satisfaction requirements.***

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality, and efficiency measures identified by OHA through a robust public process and in collaboration with stakeholders. CCO accountability metrics will function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

Accountability measures for CCOs will build on OHPB committee work over the past two years, beginning with the Incentives & Outcomes Committee and followed by the Outcomes, Quality, and Efficiency Metrics Workgroup. The next stage of metrics development will be for OHA to establish a technical advisory group of experts from health plans, health systems and to include consumers to build measure specifications, including data sources, and to finalize a reporting schedule. This stage of the work will be completed by May 2012. Further technical work, such as establishing benchmarks based on initial data, will follow as outlined below.

<u>Measurement and reporting requirements</u>
Accountability measures for CCOs should be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. Staging of accountability reporting requirements should follow a consistent schedule based on the effective date of each CCO's contract, such as:

- 0-6 months – capacity development
- 6 months - first measurement period begins
- 18 months – first report date

Depending on the measure and data source, reports may flow from CCOs to OHA or the reverse. For example, it may be advantageous for OHA to collect member experience data on behalf of CCOs just as the agency does now for MCOs. Likewise, metrics developed from claims data can come from the OHA All-Payer All-Claims (APAC) database rather than be individually collected from CCOs. While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, OHA will assess performance more frequently (e.g. quarterly) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

Accountability standards, monitoring and oversight

It is expected that with the assistance of a technical advisory workgroup, OHA will establish two levels of CCO performance standards: minimum expectations for accountability and targets for outstanding performance. Performance relative to targets will affect CCOs' eligibility for financial and non-financial rewards. CCOs' performance with respect to minimum expectations relates to accountability; subpar performance will lead to progressive remediation building on current accountability mechanisms for MCOs including technical assistance, corrective action plans, financial and non-financial sanctions, and ultimately, non-renewal of contracts. (See OHA Monitoring and Oversight in the next section.) CCOs will be expected to assess their performance, to develop quality improvement plans and goals, and to demonstrate progress toward those goals over time. However, OHA will facilitate the provision of technical assistance to assist CCOs to improve their performance with respect to accountability metrics.

As with the reporting expectations, accountability standards will be introduced over time, e.g.:

- First reporting period - performance reporting without budgetary or contractual consequences
- Second reporting period – expectation of improvement if performance is below standards
- Third reporting period - measurement against benchmarks for minimum and outstanding performance

OHA will establish a technical advisory group made up of individuals with health quality measurement expertise and use data from CCOs' first reporting period to establish baselines. Further, the technical advisory group will set standards (or benchmarks) for both minimum and outstanding performance using those baselines.

Specific areas of CCO accountability metrics

Based on input from OHPB-sponsored stakeholder work groups, CCO metrics will include both core and transformational measures of quality and outcomes:

- Core measures will be triple-aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. They will be uniform across CCOs and will encompass the range of services included in CCO global budgets (e.g. behavioral health, hospital care, women's health, etc.).
- Transformational metrics will assess CCOs' progress toward the broad goals of health systems transformation and will therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners. Minimum performance expectations should not apply to transformational measures but improvement or exceptional performance on transformational measures may qualify CCOs for financial or non-financial rewards (see Quality Incentive Payments above). CCOs will have some choice among a menu of transformational metrics.

The initial set of CCO accountability metrics and data sources will be established in consultation with the technical group and CMS in the first half of 2012 and will focus on outcomes and system transformation.

See Appendix G for examples of potential CCO accountability metrics and an example of how accountability for transformation can be shared across the system.

Annual review of CCO accountability metrics

The Board expects that CCO accountability metrics will evolve over time based on ongoing evaluation of the metrics' appropriateness and effectiveness. OHA will establish an annual review process that ensures participation from representatives of CCOs and other stakeholders including consumers and community partners.

Shared Accountability for Long-term Care

Medicaid-funded long-term care services are legislatively excluded in HB 3650 from CCO global budgets and will be paid for directly by the state, creating the possibility of misaligned incentives and cost-shifting between the CCOs and the long-term care (LTC) system. Cost-shifting is a sign that the best care for a beneficiary's needs is not being provided. In order to prevent cost-shifting and ensure shared responsibility for delivering high quality, person-centered care, CCOs and the LTC system will need to share accountability, including financial accountability.

A shared financial accountability system will be developed based on incentives and/or penalties linked to performance metrics applied to the CCO and/or to the LTC system. Other elements of shared accountability between CCOs and the LTC system may include contractual elements such as specific requirements for coordination between the two systems; requirements to clearly define roles and responsibilities between the two systems, through a memorandum of understanding, a contract, or other mechanism; and reporting of metrics related to better coordination between the two systems.

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8. Financial Reporting Requirements to Ensure Against Risk of Insolvency

- ***Section 13(3) The Authority, in consultation with the Department of Consumer and Business Services shall develop a proposal for the financial reporting requirements for CCOs to be implemented under ORS 414.725(1)(c) to ensure against the organization's risk of insolvency. The proposal must include, but need not be limited to recommendations on:***
  - ***a) The filing of quarterly [statements] and annual audited statements of financial position, including reserves and retrospective cash flows, and the filing of quarterly and annual statements of projected cash flows;***
  - ***b) Guidance for plain-language narrative explanation of the financial statements required in paragraph a) of this subsection;***
  - ***c) The filing by a CCO of a statement of whether the organization or another entity, such as a state or local government agency or a reinsurer, will guarantee the organization's ultimate financial risk;***
  - ***d) The disclosure of a CCO's holdings of real property and its 20 largest investment holdings, if any;***
  - ***e) The disclosure by category of administrative expenses related to the provision of health services under the CCO's contract with the authority;***
  - ***f) The disclosure of the three highest executive salary and benefit packages of each CCO;***
  - ***g) The process by which a CCO will be evaluated or audited for financial soundness and stability and the organization's ability to accept financial risk under its contracts, which process may include the use of employed or retained actuaries;***
  - ***h) A description of how the required statements and the final results of evaluations and audits will be made available to the public over the Internet at no cost to the public;***
  - ***i) A range of sanctions that may be imposed on a CCO deemed to be financially unsound and the process for determining the sanctions, and;***
  - ***j) Whether a new category of license should be created for CCOs recognizing their unique role but avoiding duplicative requirements by Department of Consumer and Business Services (DCBS).***

OHA will collaborate with DCBS, as required by HB 3650, to review CCO financial reports and evaluate financial solvency. HB 3650 specifies that CCOs should not be required to file financial reports with both OHA and DCBS; DCBS will be the recipient of these reporting requirements. The following section provides an overview of proposed requirements related to the above items and addresses additional information on organizational structure, corporate status and structure, existing contracts and books of business, and risk management capacities that CCOs shall report.

Audited Statements of Financial Position and Guarantees of Ultimate Financial Risk

The Department of Consumer and Business Services defines the purpose of financial regulations of insurers as being to:

> "[E]nsure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the

> initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of $2.5 million of capital and surplus for an insurer to be authorized to transact insurance. This floor increases as the company assumes more insurance risk. Capital and surplus is the amount a company's assets exceed liabilities." "Health Insurance in Oregon," DCBS; January 2009; p8

CCOs will submit financial information consistent with that required for insurers, including the use of statutory accounting principles (SAP). Application of these principles would allow for standardization of accountability and solvency assurances across health plans enrolling Medicaid, Medicare, and commercial populations and will address the CMS's interest in having organizations that enroll Medicare beneficiaries regulated by the state's Insurance Division. The filing requirements include: quarterly and annual statements of financial position using the form developed by the National Association of Insurance Commissioners (NAIC); annual actuarial certification of unpaid claim reserves, annual calculation of risk-based capital; and annual audited financial statements (using SAP). Included in the NAIC form is a schedule of retrospective cash flows and quarterly and annual statements of projected cash flows. A plain language narrative explanation of the required statements of financial position and statements of projected cash flow will be developed and made publicly available as required by statue (HB 3650 Section 13(3)(b)).

A key element for monitoring financial solvency is an understanding of a CCO's relationship and transactions with its parent, subsidiaries and affiliates. CCOs will be required to submit holding company information consistent with that required for insurers. Such information would include description of any management, service or cost-sharing arrangements and an annual consolidated audited financial statement.

Financial Solvency

It is expected that information from the NAIC financial reports will be used by financial analysts from DCBS and the Division of Medical Assistance Programs and by OHA's Actuarial Services Unit to track the financial solvency of CCOs as they gain (or lose) enrollment over time and build their financial reserves and other risk management measures commensurately. In addition, CCOs will be subject to periodic on-site financial examinations consistent with those performed on insurers. The factors below have been identified as gauges of a CCO's financial solvency; final financial reporting and solvency terms will be negotiated with CMS, which will participate regarding inclusion of Medicare funding for individuals who are dually eligible:

- *Risk-bearing entity*: As required by HB 3650, the CCO will identify whether the CCO itself or some other entity (such as a state or local government agency, or a reinsurer) will guarantee the CCO's ultimate financial risk, in full or in part. In some cases, CCOs may enter into contracts with hospitals, physician groups, or other providers to share in the financial risk (and rewards) associated with the difference between targeted or projected expenditures and actual expenditures. The extent to which these arrangements reduce the risk borne by the CCO itself will be factored into an actuary's determination of the CCO's reserves.

- *Reinsurance*: Provided through the state or purchased individually by CCOs, reinsurance will act to limit the financial risk of the CCO by capping its risk exposure on either a case-by-case or aggregate basis.
- *Claims reserves*: An adequate amount of liquid assets to satisfy claims liability is required of health plans providing commercial, Medicare, and Medicaid coverage in Oregon. Claims reserve requirements for CCOs will be actuarially determined to reflect the CCO's enrollment level and its mix of covered lives based on rate category.
  - *Medical loss ratio*: This is the ratio of expenditures (or claims) incurred for the provision of health care services divided by total health care service revenue (. Expenditures incurred for health care services is the amount paid plus the change in the unpaid claim liability. The unpaid claim liability is an estimate for claims already reported but not yet paid and an estimate of the claims for health care services used by a member that have not yet been submitted for payment.
  - *Size of the organization and risk characteristics*: Total number of insured lives and the risk characteristics across all lines of business will be considered ("risk-based capital").
  - *Enrollment level*: The predictability of CCO expenditures and the ability of the CCO to bear risk are reduced at lower enrollment levels. CMS currently requires that Medicare Advantage Plans have a minimum enrollment level of 5,000 beneficiaries. OHPB recommends that CCOs be required to file their actual and projected enrollment levels, by rate category.
  - *Organizational liability*: As required by HB 3650, CCOs will be required to file a statement identifying the entity that will be the guarantor of the CCO's ultimate financial risk and any other entities or persons sharing in that risk (in addition to identifying contracting providers bound by risk sharing agreements with the CCO).
  - *Real property, investments, and executive compensation*: As required by HB 3650, each CCO will be required to disclose their real property holdings, their 20 largest investment holdings, and executive compensation. The NAIC form for annual statements includes schedules that provide details on each of these items.
  - *Operating budget*: As described below, OHPB recommends that each CCO be required to describe an annual operating budget including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting any alternative payment methodologies implemented. This operating budget will serve both to indicate the financial soundness of the CCO and to demonstrate that the CCO has developed its budget to reflect the requirements and objectives of health systems transformation.
  - *Administrative expenses*: As required by HB 3650, each CCO will be required to outline, by category, administrative expenses relating to provision of services under its CCO contract. The NAIC form for annual statements includes a schedule of expenses by expense category. The expense schedule would show CCO expenses for all of its populations - those incurred under its CCO contract as well as contracts for other populations including Medicare, PEBB, OEBB, and other commercial insurance. Other schedules and note disclosures required by the NAIC form will provide information about expense arrangements with a parent or affiliate organization and detail amounts paid for such service arrangements. A comprehensive understanding of CCO

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administrative expenses will make possible a more accurate evaluation of the CCO's overall sustainability.

OHA Monitoring and Oversight

OHA must work in partnership with CCOs to ensure health system transformation success. OHA will institute a system of progressive accountability that maximizes the opportunity to succeed but also protects the public interest. Actions taken when access, quality or financial performance are jeopardizing members should be aligned with the categories that currently exist with DCBS. These categories reflect that OHA would become increasingly involved over time if an entity continues to miss performance guidelines with increased monitoring, technical assistance and supervision.

Quality, access and financial monitoring

Measures for monitoring and oversight in these areas should be aimed initially at root cause analysis and assisting the CCO in developing improvement strategies. Steps taken should be progressive, building on current accountability mechanism for MCOs, and may include:

- Technical assistance to identify root causes and strategies to improve
- Increased frequency of monitoring efforts
- Corrective action plan
- Restricting enrollment
- Financial penalties
- Non-renewal of contracts

Conversely, OHA may choose to offer a simplified, streamlined recertification or contracting process to high performing CCOs, in addition to the possibility of financial performance incentives,.

Monitoring of financial solvency

If a CCO's financial solvency is in jeopardy, OHA and DCBS will act as necessary to protect the public interest. These measures have two objectives: first, to restore financial solvency as expeditiously as possible; and second, to identify the causes of the threat to solvency and implement measures to prevent such threats in the future. Actions may include:

- Increased reinsurance requirements
- Increased reserve requirements
- Market conduct constraints
- Financial examinations

The ultimate action, if no effective remedy is feasible, will be loss of licensure and liquidation of assets as necessary to meet financial obligations.

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Public Disclosure of Information

Current DCBS rules require the public disclosure of information pertaining to licensed insurers. It is anticipated that these rules will also apply to CCOs.

CCO Licensure

A new licensure category will be created for CCOs by DCBS in collaboration with OHA. This new licensure category will reflect the unique requirements and objectives of health systems transformation. This will also allow the application of certain insurance code provisions to CCOs that will allow for consistency of reporting and financial solvency and comparability among CCOs and insurers but will not subject CCOs to insurance code provisions that are not necessary given their unique contracting relationship with OHA. A separate licensure category will also facilitate the blend of flexibility and accountability that will be needed for successful implementation and operation of CCOs. DCBS and OHA staff will determine whether statutory changes are required to implement a licensure category specific to CCOs, and propose such changes through the 2012 legislative process. In the interim, existing licensure categories will be used as appropriate to the populations covered.

CCOs will be expected to provide information on corporate status, participation in the Oregon Health Plan, and other contracts:

- Corporate status: where incorporated; affiliated corporate entity or entities involved under potential CCO contract; current Department of Consumer and Business Services (DCBS) licensure/certification
- Oregon Health Plan MCO or MHO status: current OHA MCO or MHO contractor status; organizational changes involved in CCO application; whether CCO is formed through MCO or MHO partnership; and MCO or MHO service area vs. CCO service area
- Other state contracts: Oregon Medical Insurance Pool (OMIP); Healthy Kids/Kids Connect; PEBB; OEBB
- Medicare contracts: CMS contracts with CCO to provide Medicare services
- Commercial contracts: both group and individual markets
- Administrative services or other management contracts

Corporate Assets and Financial Management

As part of the certification process, CCOs will provide information relating to assets and financial and risk management capabilities, including:

- Tangible net equity and other assets
- Risk reserves, current and scheduled based on enrollment and projected utilization
- Risk management measures
- Delegated Risk
- Reinsurance and Stop Loss
- Incurred but not reported (IBNR) tracking
- Claims payment
- Participation in the All Payer All Claims reporting program as required by Section 4(k)(L)

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- Internal auditing and financial performance monitoring
- Administrative cost allocation across books of business (including Medicaid, Medicare, and commercial)

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9. Implementation Plan

Transition Strategy

In addition to accommodation through appropriate levels of flexibility, incentives to form CCOs as early as possible should be integrated into the CCO certification process. OHPB recommendations for such incentives include, but are not limited to, the following options:

- *Financial incentives*: Global budget adjustments, annual trend rates, and incentive payments or enhanced federal financial payments, if available, could be structured to support CCOs, providing financial incentives to form the new organization early. This approach provides not only strong incentives and resources for CCOs, but also underscores the urgency and priority of health system transformation.
- *Enrollment incentives*: Building up sufficient enrollment to mitigate risk is essential for CCO start-up. New eligibles and those due for annual redetermination should be automatically enrolled in CCOs. This strategy will need to take in to account the choice and notification of enrollees, including those eligible for both Medicare and Medicaid.
- *Flexibility incentives*: Efforts to provide flexibility in service delivery and administration should be directed first and foremost to CCOs.
- *Technical assistance and training incentives*: CCOs will benefit from the learning collaborative that OHA will establish, as required by HB 3650, and from state-level work to accumulate evidence about and disseminate information on innovative service delivery practices. If OHA successfully applies for and receives enhanced federal financial contributions for workforce training, then these funds would also be made available to CCOs that invest in developing the alternative workforce identified in HB 3650 including community health workers, peer wellness specialists, and personal health navigators.

Transitional Provisions in HB 3650

In the case of an area of the state where a CCO has not been certified, Sections 13 and 14 of HB 3650 require continued contracting with one or more prepaid managed care health services organizations in good standing and already serving that area. In addition, HB 3650 requires these organizations to fulfill a substantial portion of CCO responsibilities including specific service offerings, organizational structure, patient-centered primary care homes and other system delivery reforms, consumer protections, and quality measures. Continued contracting with prepaid managed care health services organizations will reflect these statutory requirements. MCO contracts will be amended to reflect the requirements of HB 3650 in parallel to the certification process for CCOs.

Implementation Timeline

The sequence below indicates key timeframes for MCOs and MHOs transitioning to CCO status (dates are approximate and subject to legislative and CMS approval):

<u>Rules</u>:

March 2012	OHA will release temporary administrative rules defining CCO criteria and other administrative rule changes as necessary

June-Sept 2012	OHA administrative rules process to finalize CCO/MCO changes that includes the required Rules Advisory Committee

<u>CCO Applications:</u>

March 2012	OHA will release CCO application, with Letter of Intent
April 2012	CCO applicants will submit applications to demonstrate that they meet CCO criteria to OHA
April-May 2012	OHA will evaluate CCO applications
June 2012	OHA will certify CCOs (CMS will approve CCOs for enrollment of dually eligible)

<u>Contracts:</u>

March 2012	CCO estimated cost submission process defined (including public comment process) and release of CCO Base Cost template
April 2012	CCO applicants will submit notices of intent to contract and, subsequently, base cost estimates
April –June 2012	State to negotiate CCO contracts and budget (CMS will participate regarding inclusion of Medicare funding for dually eligible) April-May: OHA Review and Certification of CCO Rates May: Final Review of CCO budget June: CCO budget Submitted to CMS June: Contract to CCO July 1: Effective date of CCO Contract July 31: 3-way contracts signed between CCO/state/CMS (may come behind OHA contracts, as a contract amendment or rider)

<u>Implementation:</u>

June-August 2012	State and CMS conduct “readiness review” of certified CCOs for inclusion of the dually eligible (CMS will participate regarding inclusion of Medicare funding for dually eligible)
July-September 2012	CCOs passing Medicare “readiness review” can begin preparing for enrolling dually eligible individuals for Medicare services
July 2012	First CCOs enroll Medicaid beneficiaries
July 2012	HB 3650 Sections 4, 6, 8, 10, and 12 take effect for MCOs
September 30, 2012	Current MCO contracts due for renewal
January 2013	CCOs begin providing Medicare services to dually eligible beneficiaries

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10. Appendices

A. Managed care plan types and service areas
B. Financial projections and potential savings tables (*forthcoming*)
C. Proposed Alternative Dispute Resolution (ADR) process
D. CCO Criteria Matrix (criteria detail)
E. Table of eligibles for CCO enrollment and current managed care enrollment status
F. Program List
G. Accountability framework and example metrics

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Appendix A:
Current Managed Care Plans and Service Areas

Fully Capitated Health Plans (FCHP) and Physician Care Organizations (PCO)

Plan	Organization Type	Counties Served
Care Oregon, Inc.	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Yamhill, Washington
Cascade Comprehensive Care, Inc.	FCHP	Clackamas, Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Linn, Malheur, Marion, Multnomah, Polk, Umatilla, Union, Wasco, Washington, Yamhill
DCIPA, LLC	FCHP	Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Tillamook, Union, Washington, Yamhill
Docs of the Coast South	FCHP	Benton, Clackamas, Coos, Curry, Deschutes, Douglas, Hood River, Jackson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Union, Washington, Yamhill
Family Care, Inc.	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
Intercommunity Health Network	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Harney, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
Kaiser Permanente or Plus, LLC	PCO	Baker, Clackamas, Clatsop, Columbia, Coos, Deschutes, Douglas, Jackson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Sherman, Umatilla, Wasco, Washington, Yamhill
Lane Individual Practice Association	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Washington, Yamhill
Marion Polk Community	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Sherman, Tillamook, Umatilla, Wallowa, Wasco, Washington, Yamhill
Mid-Rogue Holding Company	FCHP	Baker, Benton, Clackamas, Coos, Crook, Curry, Deschutes, Douglas, Jackson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Marion, Multnomah, Umatilla, Union, Washington
ODS Community Health, Inc.	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
Oregon Health Management Services	FCHP	Benton, Clackamas, Coos, Curry, Deschutes, Douglas, Jackson, Josephine, Klamath, Lane, Linn, Marion, Multnomah, Sherman

Plan	Organization Type	Counties Served
Pacific Source Community Solutions, Inc.	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Providence Health Assurance	FCHP	Benton, Clackamas, Clatsop, Columbia, Coos, Deschutes, Gilliam, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Marion, Multnomah, Polk, Sherman, Tillamook, Wasco, Washington, Yamhill
Tuality Health Alliance	FCHP	Baker, Benton, Clackamas, Clatsop, Columbia, Deschutes, Douglas, Harney, Jackson, Josephine, Lane, Lincoln, Marion, Multnomah, Polk, Tillamook, Washington, Yamhill

Mental Health Organizations (MHO) and Dental Care Organizations (DCO)

Plan	Organization Type	Counties Served
Access Dental Plan, LLC	DCO	Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Deschutes, Douglas, Gilliam, Grant, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
Accountable Behavioral Health	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Advantage Dental	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Capitol Dental Care, Inc.	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Clackamas Mental Health Organization	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Family Care, Inc.	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Family Dental Care	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Hood River, Jackson, Jefferson,

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Plan	Organization Type	Counties Served
		Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Sherman, Tillamook, Union, Washington, Yamhill
Greater Oregon Behavioral Health, Inc.	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Jefferson Behavioral Health	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
Lane Care	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Managed Dental Care of Oregon	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
Mid Valley Behavioral Care Network	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
Multicare Dental	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill
Multnomah Verity	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
ODS Community Health, Inc.	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Wheeler, Yamhill
Pacific Source Community Solutions, Inc.	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wasco, Washington, Yamhill
Washington County Department of Mental Health	MHO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco,

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Plan	Organization Type	Counties Served
		Washington, Yamhill
Willamette Dental Group	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lake, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill

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APPENDIX C

Introduction to
Dispute Resolution Process Outline

HB 3650 required the development of a process that involves the use of an independent third party arbitrator to resolve disputes when a necessary health care entity (HCE) refuses to contract with an organization seeking to form a coordinated care organization (CCO). The process must be presented to the Legislative Assembly for approval. This outline was developed by OHA, with input from an external stakeholder work group.

HB 3650 Section 8(4) – (7) provides as follows:

> (4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.
>
> (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.
>
> (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.
>
> (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.

Scope: Section 4 shows that this statutory process applies when an organization is seeking to form a CCO and participation by a health care entity (HCE) is necessary for the organization to qualify as a CCO. As a result, the proposed process is limited to the certification of CCOs and only when the HCE is necessary for the organization to qualify as a CCO. This limited scope is also consistent with the substantial statutory remedy in subsection (6) for an unreasonable refusal to contract by an HCE.

Who is qualified to serve as an arbitrator? Statute is silent about who is qualified to serve as an arbitrator in this process, except to require the "use of an independent third party arbitrator." OHA recommends that the CCO applicant and the HCE use any qualified independent third party arbitrator that they agree upon. The proposed process provides some minimal recommendations for the qualifications of the arbitrator. The arbitrator must:

- Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
- Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650

Length of time for arbitration process: Since Section 8 establishes this arbitration process when an organization is seeking to become qualified as a CCO, a dispute with a necessary HCE should be resolved promptly. A timeline of 60 calendar days is recommended once an arbitration process is initiated by one of the parties. Extending the time should require the written agreement of both parties.

PROCESS FOR RESOLVING DISPUTES UNDER SECTION 8(4) - (7)

Preliminary good faith negotiations: GOAL – the parties voluntarily agree on terms and enter into contracts

1. Organization is seeking to become certified as a CCO (Applicant) and:
    a. Applicant asserts that a health care entity (HCE) is necessary for Applicant to qualify as a CCO;
    b. An HCE asserts that its inclusion is necessary for Applicant to be certified as CCO; or
    c. OHA, in reviewing Applicant information, identifies the HCE as necessary for Applicant to qualify as CCO.
2. If there is disagreement between an Applicant and HCE regarding whether the HCE is "necessary", the Applicant or HCE can request review from OHA about whether the HCE may be considered "necessary" for an Applicant to qualify as a CCO.
    a. If the specific HCE is deemed by OHA as not "necessary" for Applicant to be certified as a CCO, then this specific process does not apply per Section 8.
    b. The process described below only applies where an HCE is deemed by OHA as "necessary" for the Applicant to be certified as a CCO (or the parties agree that the HCE is "necessary" for an Applicant to qualify as a CCO), in accordance with Section 8.
3. If deemed by OHA as "necessary" or the parties agree that the HCE is "necessary", the HCE and Applicant participate in contract negotiations.
    a. Goal: Applicant and HCE agree on terms and enter into a contract.
4. Request for technical assistance from OHA – voluntary.
    a. Either Applicant or HCE may request OHA technical assistance.
    b. OHA may offer technical assistance. OHA assistance will be confined to clarification of the CCO certification process and criteria, and other program requirements.
5. Before requesting referral to this dispute resolution process, the parties should take the following actions in an attempt to reach a good faith resolution between the Applicant and the HCE:
    a. The Applicant has provided a written offer of terms and conditions to the HCE and the HCE has explained to the Applicant the source of disagreement, if any.
    b. Before referral, the CFO or CEO of each organization have had at least one face-to-face meeting in a good faith effort to resolve the source of disagreement.
    c. Goal: Applicant and HCE agree on terms and enter into a contract.

6. If the Applicant and HCE are unable to reach agreement on contract terms within 10 calendar days of the HCE and Applicant face-to-face meeting in 5(b), either party can notify the other party in writing to initiate referral to an independent third party arbitrator. (At that time, the party initiating the referral will provide a copy of the notification to the OHA.) The arbitrator must:
    a. Be knowledgeable and experienced as an arbitrator, and generally familiar with health care matters; and
    b. Agree to follow the terms and conditions specified for the arbitration process, described below, and become familiar with HB 3650.

Arbitration Process – NOTE: At any point in this process, the CCO and HCE can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

1. After notification that arbitration is being initiated, the parties agree upon the arbitrator and complete paperwork required to secure the arbitrator's services – costs for arbitration to be borne by the parties. (Estimated 15 calendar days) NOTE: Any changes to the time periods described in this process requires the written agreement of both parties.
2. Once referral is completed (step 1), the Applicant and HCE have 10 days to submit to each other and the arbitrator their most reasonable contract offer (10 calendar days) or submit a statement from the HCE that no contract is desired and why this is reasonable.
3. The parties then have 10 days from receipt of the other party's offer, or HCE statement that no contract is desired, to submit to the arbitrator and the other party their advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the Applicant. (10 calendar days)
    a. Legal standards for arbitration:
        i. A HCE may reasonably "refuse to contract with a CCO if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service" – per Section 8(5)

            NOTE: Where statute establishes particular reimbursement requirement (e.g., Type A and B hospitals, federally qualified health centers, rural health centers, providers of Indian health services), those laws shall govern the determination of reasonable cost.
        ii. Except as provided in (i), a HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the legislative policies described in Sections 1 – 4 of HB 3650. Some examples of facts or circumstances pertinent to what is "unreasonable" includes but are not limited to:

            1. Whether participation in the CCO contract imposes demands on the HCE that the HCE cannot reasonably meet without negative impact on HCE costs in the context of the proposed reimbursement arrangement,

including but not limited to use of electronic health records, service delivery requirements, or quality or performance requirements.

2. Whether refusal to contract by the HCE impacts access to covered services in the community that should be provided by the CCO. This factor alone should not be used to find a refusal to contract unreasonable, but it is recognized that HCEs and CCOs should be encouraged to make a good faith effort to work out differences in order to achieve beneficial community objectives and the policy objectives of HB 3650

4. Arbitrator determination and final opportunity to settle:
    a. The arbitrator must evaluate the final offers/statement of refusal to contract and the advocacy briefs from each party and issue a determination within 15 calendar days of the receipt of the parties' arguments about whether the refusal to contract is reasonable or unreasonable. (15 calendar days)
    b. The arbitrator's determination will be provided to the parties and not disclosed publicly to the OHA for a period of 10 calendar days, to allow the parties an opportunity to resolve the contract issue themselves. (10 calendar days)
    c. If the parties have not voluntarily reached an agreement regarding contract terms after the 10 day period, the arbitrator's decision must be released to the OHA. Once released to OHA, the arbitrator's decision will be a public record, subject to protection of trade secret information if identified by one of the parties prior to submission to OHA. (Total time = 60 calendar days)

APPENDIX D: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

This document reflects ongoing OHA/DHS staff analysis of issues relating to the statement of work and certification criteria for Coordinated Care Organizations (CCOs) that will contract with OHA under HB 3650. It will be revised and expanded over the next several months to reflect discussion and input from the External Work Groups appointed by the governor, feedback from other stakeholders, discussion and recommendations from the Oregon Health Policy Board, and guidance from the 2012 Legislative Session. **This is a working document and is for discussion purposes only.**

Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
Governance Structure: **Each CCO has a governance structure that includes:** • **a majority interest consisting of the persons that share the financial risk of the organization** • **the major components of the health care delivery system, and** • **the community at large, to ensure that the organization's decision-making is consistent with the values of the members of the community**	CCO clearly articulates: • selection criteria for governing members and assures transparency in governance—who the decision makers are, how decisions are made and how decision-making is linked with the work of the Community Advisory Council, and • How the governing board makeup reflects community needs and supports the goals of health care transformation.		• Feedback from the Community Advisory Council • Member experience or satisfaction surveys	
Community Advisory Council: **Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of the membership and that meets regularly to ensure that the health care needs of the consumers and**	• CCO establishes a CAC grounded in an assessment of community health needs and a process that assures the CAC reflects the diversity of the community. • A member of the CAC sits on the governing board • CCO employs best practices to support engagement and	• CCO assures collaboration between the CAC and the governing board on policy formulation and other decision-making affecting patient care and health outcomes.	• Community needs assessment results • Consideration of CAC recommendations in Board meeting in minutes	

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the community are being met	participation of members, including those facing barriers to participation.			
<u>Nonprofit Agencies</u>: The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.	• CCO has plans for developing and maintaining linkages between local government agencies and other nonprofit agencies in the configuration of CCOs.			
<u>Dental Care Organizations</u>: On or before 7/1/14, each CCO will have a formal contractual relationship with any DCO in its service area	• CCO has a plan for forming contractual relationships with any DCO in its serve area on or before 7/1/14.	• CCO has taken concrete steps towards forming contractual relationships with any DCO that services members of the CCO in the area where they reside on or before 7/1/14. • CCOs will need to ensure network adequacy for dental care providers; provide navigation assistance to access dental care, and make appropriate referrals for chronic diseases related to oral health issues.		
<u>Person-centered Care</u>: Each member receives integrated person-centered care and services designed to provide choice, independence and dignity	• Members should be reassessed at least annually to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.		• Patient experience of care data (e.g. CAHPS measures) • Shared decision making measures	
<u>Safeguards for Members</u>:	• CCO adheres to safeguards for	• CCO adheres to safeguards		

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CCO complies with safeguards for members as described in Section 8, Consumer and Provider Protections, of HB 3650	members as described in Section 8 of HB 3650.	for members as described in Section 8 of HB 3650. In addition, CCO supports members by carrying out (1)(a) – (e) to the greatest extent feasible.		
Patient Engagement: **CCO operates in a manner that encourages patient engagement, activation, and accountability for the member's own health.**	• CCOs will perform an upfront assessment of member's capacity for participating effectively in advocating and coordinating their own care. • CCO demonstrates how it will facilitate activation of its enrolled population, understanding to the greatest extent feasible, how the approach taken will take into consideration the social determinants of health. • OHA may provide a clearinghouse of best practices for CCOs and disseminate best practice information when available.	• CCO provides resources based on member's Patient Activation level (1, 2, 3 or 4). • CCO demonstrates they are training and engaging their providers to facilitate patient and family/caregiver's engagement.	• CCO assesses members' activation levels) • Activation improvement over time: X% of members improving by Y% in Z amount of time	
Member Access and Provider Responsibilities: **Members have *access* to a choice of providers within the CCO's network and that providers in the network:** • **work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of**	• CCOs must ensure that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions. • Ensure access to primary care where screenings can occur to determine if a higher level of care is needed.	• CCOs will ensure a breadth of providers capable of providing services across the continuum of care with a multidisciplinary, holistic and team approach.	• Community needs assessment results	

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Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
members • **are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history** • **emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication** • **are permitted to participate in networks of multiple CCOs** • **include providers of specialty care** • **are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards** • **work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members**	• Ensure providers are working at the top of their license.			
<u>Member and Care Team</u>: **Each member has a consistent and stable relationship with a care team that is responsible for providing**	• CCO has a significant percentage of members enrolled in patient centered primary care homes (PCPCHs) certified at least as Tier 1	• CCO demonstrates that an increasing number of their enrollees will be served by certified PCPCHs and that	• % of members in a PCPCH • % of PCPCHs certified as Tier 3 (highest level) • A delivery system network	

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preventive and primary care, and for comprehensive care management in all settings	according to Oregon's standards. • CCO demonstrates ability to offer enrollees a comprehensive delivery system network with the PCPCH at the center, with other health care providers and local services and supports under arrangement for comprehensive care management.	those PCPCHs will be moving toward Tier 2 and 3 of the Standards. • CCO demonstrates a comprehensive approach to care management by developing meaningful relationships between PCPCHs, the health care community, state and local government, and community services and supports.	plan that includes network development activities, on-going management, and technical assistance for providers. • Data that identify utilization by provider type with a plan to address shifts in care within the delivery system.	
<u>Holistic Care through Primary Care Homes</u>: **Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible**	• CCO develops a process to conduct health screenings for members to assess individual care needs. • Each member shall have an individual care plan for physical and behavioral health care needs, inclusive of social support needs (e.g., community resources and housing). Individual care plans shall consider specific treatment plans from all providers.		• X% of members receive health screen in year 1 • X% of high risk members have individualized care plan in year 1 • % of eligible members have a personalized care plan established within X days of enrollment	
<u>Transitional Care</u>: **Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long term care setting**	• CCO develops plan to address transitional care for members facing admission or discharge from hospital, hospice or other palliative care, home health care, adult foster care, or skilled nursing care.	• CCO has ability to track member transitions from one care setting to another, including engagement of the member and family members in care management and	• Follow-up after hospitalization: % discharged from inpatient care who have a follow-up visit within X days • Care Transition Measure (CTM-3): 3-item	

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		treatment planning. Tracking system may include appropriate follow-up guidelines, alerts, and reporting.	questionnaire measuring quality of patient preparation for transitions (understanding own role; medication reconciliation; incorporation of personal preferences into care plan)	
<u>Navigating the System</u>: Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, community health workers and personal health navigators who meet competency standards established by the Authority	• CCO provides access to non-traditional health workers, and assists members to navigate the health care system and facilitates appropriate linkages to state and local government agencies and community and social support service organizations to capitalize on available resources for different members' needs.	• All CCO members have full support in navigating the health care system and in accessing the full range of services and supports available through state and local government and other community and social support services that may be provided by both traditional and non-traditional health workers.	• Ratio of non-traditional health workers to enrollees • % of members assigned to a non-traditional provider(s) that is appropriate for their needs	
<u>Accessibility</u>: Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations	• CCO has a delivery system network that provides appropriate access to needed health care services close to where members reside that may also include non-traditional settings and community services and supports.	• CCO manages a comprehensive delivery system network based on patient-centered primary care homes and inclusive of non-traditional settings. • CCO identifies underserved populations and addresses their health disparities, adjusting services and settings to match their needs.		

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<u>High Need Members</u>: **Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions**	• A substantial percentage of high risk members have an individualized care plan.	• CCO develops a system to identify and track high-risk members and their outcomes, including avoidable ED visits and hospital admissions. • Provider network capacities are adjusted to reflect changes in the need for and use of preventive services, remedial and supportive care, emergency care, and hospital care.	• Rate of avoidable hospitalizations • Rate of non-emergent ED visits • Measures of patient engagement or patient activation	
<u>Learning Collaborative</u>: **Each CCO participates in the learning collaborative described in ORS 442.210**	• CCO participates in the learning collaborative described in ORS 442.210 that engages state and local government, private health insurance carriers, third party administrators, patient-centered primary care homes, other critical health care providers, state and local government, and community and social support services.			
<u>Patient Centered Primary Care Homes</u>: **Each CCO shall implement, to the maximum extent feasible, patient-centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse**	• CCO works with participating Patient-Centered Primary Care Homes (PCPCHs) to develop a comprehensive Delivery System Network (DSN) and to assure effective person-centered care planning and coordination which may be evidenced by a plan.		• x% of CCOs' primary care network is PCPCH by end of year 1 • x% of primary care network is Tier 3 PCPCH by year 3	

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communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.	• CCO requires their other contracting health and services providers to communicate and coordinate with the PCPCP in a timely manner using electronic health information technology, where available.			
<u>Health Equity</u>: **Health care services…focus on…improving health equity and reducing health disparities** Ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors.	• CCO demonstrates an understanding of the diverse communities and health disparities in its service area (e.g. via a needs assessment) and describes an approach to substantially reducing these health inequities over time.	• CCO demonstrates meaningful and systematic engagement with critical populations in its community to create and implement plans for addressing health equity and health disparities.	• Community needs assessment results • A comprehensive community oriented health equity plan.	
	• CCO demonstrates how it will address disparities in the delivery of health care services and in health outcomes (access to care, quality of care, chronic disease management, care coordination, provider communication, etc.) and how they will ensure cultural competence.	• CCO develops long term plans that incorporate innovation over time to substantially reduce disparities relating to the social determinants of health, including race and ethnicity in combination with age, income, gender, and other factors.	• Reduction of unwarranted variations in care and outcomes by race, ethnicity, primary language and other factors.	
<u>Alternative Payment Methodologies</u>: **OHA encourage CCOs to use alternative payment methodologies**	• CCOs will need to move from a predominantly fee-for-service system to alternative payment methods that base reimbursement	• CCOs will effectively implement alternative payment approaches to create incentives for		

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that: • **reimburse providers on the basis of health outcomes and quality measures instead of the volume of care** • **hold organizations and providers responsible for the efficient delivery of quality care** • **reward good performance** • **limit increases in medical costs** • **use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination**	on the quality rather than quantity of services provided.	evidence-based guidelines and best practices that will be expected to increase health care quality and patient safety and result in more efficient use of health care services. • CCOs will build provider capacity to help restructure practices to be able to respond effectively to new payment incentives.		
<u>Health Information Technology</u>: Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable	• CCO documents its level of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and develops a HIT improvement plan for meeting transformation expectations. • CCO participates in a Health Information Organization (HIO) or is registered with a statewide or local Direct-enabled Health Information Service Provider	• CCO providers have EHR/HIE capacity to send and receive patient information in real time, and CCOs have the analytic capacity to assess patient outcomes of care coordination.	• % providers within CCO that meet Meaningful Use criteria • % of CCO providers who have an EHR • % of e-prescriptions, electronic lab orders and clinical summaries shared electronically • Meeting milestones/goals of HIT improvement plan	

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<u>Outcome and Quality Measures</u>: Each CCO reports on outcome and quality measures identified by the Authority under Section 10 and participates in the All Payer All Claims data reporting system	• CCO reports an acceptable level of performance with respect to identified metrics, following a consistent schedule based on the effective date of each CCO's contract. • CCO submits APAC data in a timely manner according to program specifications.	• CCO reports exceptional performance with respect to identified metrics.	• Patient experience of care • Hospital readmission rates • Access (e.g. time from CCO enrollment to first encounter, and type of encounter) • HbA1C control • Etc.	• Data timeliness • Availability of clinical data
<u>Transparency</u>: CCO is transparent in reporting progress and outcomes.	• CCO provides OHA with detailed quality, efficiency, and outcome data (not aggregate results). • CCO has performance feedback loop to contracted entities and providers. • CCO makes aggregate performance information available to members.	• CCO has system in place to provide timely performance and outcomes data to all stakeholders.		
<u>Best Practices</u>: Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks	• CCOs will address these subjects in their applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650. • CCOs will establish a Clinical Advisory Panel (CAP) to ensure clinical best practices. The CAP		• Annual reports	

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Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
	should be represented on the CCO governing board, similar to the CAC.			

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APPENDIX E - Overview of CCO eligible populations

Oregon Medicaid Caseload for Inclusion in Coordinated Care Organization (CCO) Global Budgets
Includes Managed Care and Fee For Service

	Total	Medical		Dental		Mental Health	
Populations Included in CCO Global Budgets	**Eligibles**	**FCHP + PCO***	**FFS**	**DCO**	**FFS**	**MHO**	**FFS**
OHP Plus (Categorical Pops)	**362,182**	287,049	75,132	320,790	41,392	314,177	48,005
SCHIP (ages 0-18)	**58,473**	52,236	6,237	55,721	2,753	55,314	3,160
OHP Standard (1115 Expansion Population)	**46,206**	38,471	7,735	42,084	4,122	42,058	4,148
Fully Dual Eligible	**58,675**	33,967	24,709	52,080	6,595	50,532	8,143
Subtotal	**525,537**	**411,723**	**113,813**	**470,674**	**54,862**	**462,080**	**63,456**
To Be Decided							
Citizen Alien Waived Emergent Medical - Prenatal	**1,138**	-	1,138	-	1,138	-	1,138
Citizen Alien Waived Emergent Medical	**22,558**	-	22,558	-	-	-	-
Breast and Cervical Cancer Program - Medical	**444**	-	444	-	444	-	444
Subtotal	**24,140**	**-**	**24,140**	**-**	**1,582**	**-**	**1,582**
Grand Total	***549,677***	***411,723***	***137,954***	***470,674***	***56,445***	***462,080***	***65,039***

* FCHP - Fully Capitated Health Plan
PCO - Physician Care Organization

Notes:
- Medical, Dental and Mental Health eligibles should *not* be added together to reach totals. Rather, most beneficiaries are eligible for all three types of services and are therefore counted separately under each.
- OHP Plus includes: Temporary Assistance to Needy Families-Medical, Poverty Level Medical Adults, Poverty Level Medical Children, Aid to the Blind and Aid to the Disabled, Old Age Assistance, and Foster Care, Substitute or Adoptive Care Children.
- SCHIP includes ages 0 to 18, excludes CAWEM Prenatal.
- Eligibility categories do not include Family Health Insurance Assistance Program, Healthy Kids Connect, CHIP Employered-Sponsored Insurance.

Staff reference:
09-11 Dec Rebal; includes FFS and Managed Care.

APPENDIX F
Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid Program/Services	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Physical Health Programs*				
Physical health coverage, including emergency transport, FCHP administrative, hospital reimbursement allowances, FQHC wraparound, and pass through.	Depending on benefit package, includes medical care from a physician, nurse practitioner or physician assistant; hospital care; hospice care; laboratory and x-ray; medical equipment and supplies; emergency medical transportation; physical, occupational and speech therapy; prescription drugs (excluding mental health drugs); vision services and other covered services.	Fully capitated health plans, Physician Care Organizations	Y	52%
		FFS Only		18%
Dental coverage, including DCO administrative**	Includes basic dental services, urgent/immediate treatment and other services.	Dental Care Organizations	Y	5%
Non-emergency medical transportation	Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation for Medicaid eligibles to access OHP covered services when no alternative transportation is available.	Transportation Brokerages & FFS		2%
Citizen Alien Waived Emergent Medical (CAWEM)	Emergency medical services to non-citizens who are eligible for medical assistance except they do not meet the Medicaid citizenship and immigration status requirements.	FFS Only		1%
Citizen Alien Waived Emergent Medical (CAWEM) Prenatal Program	Prenatal care to pregnant women who are currently only eligible for CAWEM Emergency Medical. (Only in select counties; voluntary enrollment only)	FFS Only		<1%
Breast and Cervical Cancer Program - Medical	Provides access to medical care for low-income, uninsured, and medically underserved women diagnosed with breast or cervical cancers	FFS Only		<1%
Behavioral Rehabilitation Services (Leverage)	Services provided by a child-caring agency in a shelter, residential or therapeutic foster care placement setting to remediate psychosocial, emotional and behavioral disorders.	FFS Only		<1%
Targeted Case Management (Leverage)	Assists eligible clients in gaining access and effectively using medical, social, educational, and other services.	FFS Only		<1%

* Class 7 & 11 mental health drugs are not included in this list because House Bill 3650 excludes them from CCO global budgets. However, they are included in the total expenditures used to calculated percentages in this table.
** Dental Care Organizations are not required to enter in to contracts with CCOs until July 1, 2014, but may do so at an earlier date.

APPENDIX F
Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid Program/Services	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Addictions & Mental Health Programs				
Mental Health Coverage including MHO administrative	Medicaid funded ambulatory assessment and treatments (based on the prioritized list) of mental health conditions provided in community-based settings by licensed practitioners or non-licensed personnel employed by agencies with a certificate of approval by OHA/AMH.	Mental Health Organizations	Y	8%
		FFS Only		1%
Adult Community Residential Mental Health Services	Mental health services provided in a residential setting.	CMHP		3%
Addiction health coverage	Ambulatory assessment and treatments (based on the prioritized lit) of substance use disorders provided by licensed professionals or non-licensed personnel employed by agencies.	FCHPS and PCOs	Y	1%
		FFS Only		<1%
Adult residential alcohol and drug treatment***	Alcohol and drug treatment provided in a residential setting.	CMHP and direct contracts w/providers		<1%
Residential mental health for non-forensic children	Mental health services provided in a residential setting.	MHO plus provider direct billing to DMAP for non-MHO enrolled children	Y	<1%
Youth residential alcohol and drug treatment ***	Alcohol and drug treatment services provided in a residential setting	None - Direct contracts with all providers		<1%
Psychiatric Day Treatment Service for Children	Psychiatric day treatment service delivered in a facility-based setting.	MHO-provider direct billing to DMAP for non-MHO enrolled kids	Y	<1%
Children's Statewide Wraparound	Services and supports for children with complex behavioral health needs and their families.	MHO	Y	<1%
Personal Care 20 Client Employed Provider for People with Mental Illness	Intensive community or in-home supports to assist Medicaid eligible, disabled individuals with activities of community living.	Client employs provider		<1%

*** Residential alcohol and drug treatment providers are not required to enter in to contracts with CCOs until July 1, 2013, but may do so at an earlier date.

APPENDIX F
Example List of Medicaid Services and Programs For Inclusion in CCO Global Budgets

Medicaid Program/Services	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Seniors & People with Disabilities	**Descriptions**			
Payment of Medicare premiums for dual eligibles	Medicare premium payments for dually eligible paid by Medicaid	N/A	Y	4%
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Applicable deductibles, coinsurance, and copayment amounts for dually eligible enrollees	N/A		<1%
OHP Post Hospital Extended Care	Provides a stay of up to twenty days in a nursing facility to allow for discharge from a hospital to a nursing facility	FFS Only	Y	<1%
Public Health	**Descriptions**			
School-Based Health Center Services	Comprehensive primary care clinics that provide physical, mental and preventive health services to school-aged children in a school-based setting.	Local Public Health Authority (LPHA)		1%
Babies First!	A Medicaid funded nurse home visiting program for families with babies & young children up to 5, with significant health & social risks. Provides health assessments, aligns community resources, strengthens parenting skills, and improves infant health outcomes.	Local Health Departments		<1%
Maternity Case Management	An education and support program for pregnant women on Medicaid with social or health concerns during pregnancy to improve health outcomes.	Local Health Departments (DMAP provides reimbursement for MCM services to a broader community of prenatal care providers not under the public health program)		<1%

Appendix G
Principles, Domains and Example CCO Accountability Metrics

OHPB Stakeholder Workgroup on Outcomes, Quality, and Efficiency Metrics

Potential CCO Performance Measures

At a minimum, any selected performance measure selected should meet standard scientific criteria for reliability and face validity. Potential measures should also be evaluated against the principles below, with the goal of establishing a set of CCO performance measures that reasonably balances the various criteria. OHA should re-examine selected measures on a regular basis to ensure that they continue to meet criteria.

Principle	**Selection criteria**	**Change criteria**
Transformative potential	o Measure would help drive system change	o Measure reinforces the status quo rather than prompting change
Consumer engagement	o Measure successfully communicates to consumers what is expected of CCOs	o Measure is not understandable or not meaningful to consumers
Relevance	o Condition or practice being measured has a significant impact on issues of concern or focus* o Measure aligns with evidence-based or promising practices	o Lack of currency - measure no longer addresses issues of concern or focus*
Consistency with existing state and national quality measures, with room for innovation when needed	o Measure is nationally validated (e.g. NQF endorsed) o Measure is a required reporting element in other health care quality or purchasing initiative(s) o National or other benchmarks exist for performance on this measure	o Measure loses national endorsement o Measure is unique to OHA when similar standard measures are available
Attainability	o It is reasonable to expect improved performance on this measure (can move the meter)	o CCO or entity performance is "topped out" o Measure is too ambitious
Accuracy	o Changes in CCO performance will be visible in the measure o Measure usefully distinguishes between different levels of CCO performance	o Measure is not sensitive enough to capture improved performance o Measure is not sensitive enough to reflect variation between CCOs

SAMPLES

Feasibility of measurement	o Measure allows CCOs and OHA to capitalize on existing data flows (e.g. state All Payer All Claims reporting program or other established quality reporting systems) o Data collection for measure will be supported by upcoming HIT and HIE developments	o Burden of data collection and reporting outweighs the measure's value
Reasonable accountability	o CCO has some degree of control over the health practice or outcome captured in the measure	o Measure reflects an area of practice or a health outcome over which CCO has little influence
Range/diversity of measures	o Collectively, the set of CCO performance measures covers the range of topics, health services, operations and outcomes, and populations of interest	o There is a surplus of measures for a given service area or topic o Measure is duplicative o Measure is too specialized

* These issues include, but are not limited to: health status, health disparities, health care costs and cost-effectiveness, access, quality of care, delivery system functioning, prevention, patient experience/engagement, and social determinants of health.

Domains of Measurement

OHA should assess CCO performance in two primary domains:

- Accountability for system performance in all service areas for which the CCO is responsible:
  - Adult mental health
  - Children's mental health
  - Addictions
  - Outpatient physical
  - Inpatient physical
  - Women's health
  - Dental
  - Prevention
  - End-of-life care

- Accountability for transformation:
  - Care coordination and integration
  - Patient experience and activation
  - Access
  - Equity
  - Efficiency and cost control
  - Community orientation

EXAMPLES

Potential CCO Performance Measures
Examples Only

- Rate of tobacco use among CCO enrollees
- Obesity rate among CCO enrollees
- Low birth weight
- Breastfeeding exclusivity at 6 months
- Well child visits
- Dental visits (% of members with any visit in past year)
- Wait time for dental visit
- Depression screening
- Alcohol screening (e.g. SBIRT)
- Initiation & engagement in drug, alcohol, and mental health treatment
- Penetration rate for mental health and chemical dependence treatment
- Cholesterol control for patients with CAD
- Cholesterol control for patients with diabetes
- Glucose control for diabetics
- Cancer screening (1 of: cervical, breast, or colorectal)
- Effective contraceptive use and unintended pregnancy
- Chlamydia screening
- Fall risk screening (older adults)
- Service engagement (% members who received no health services at all in x period)
- Member or patient experience with:
  - Getting needed care & getting care quickly
  - Shared decision making and participation in care planning
  - Care coordination
  - Chronic disease self-management support
  - Primary provider or provider team
  - Overall experience of care
- Primary care-sensitive hospital admissions (AHRQ PQIs)
- ED visits by primary diagnosis (e.g. mental health, substance abuse, dental, other)
- Hospital acquired infection rates
- Medication management (e.g. % discharges where medications were reconciled within 7 days)
- Follow-up after hospitalization (visit within 7 days of discharge for physical or mental health diagnosis)
- Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)
- End of life care preferences (e.g. % dual eligibles or age-specified members who have a POLST form on file)
- Health status improvement
- Functional status improvement

EXAMPLES

Accountability by Level

Illustrative examples for discussion purposes only

Example Domain: Care Coordination

	CCO Criteria (Structure)	Process Metrics	Outcome Metrics	Triple Aim
Macro: **OHA**	Establish recognition process for PCPCHs	• # of PCPCHs recognized	• % of OHA-covered lives with access to PCPCH • OHA roll-up: ambulatory care-sensitive hospital admissions	Better care, lower costs
	Administer EHR incentive program Facilitate HIE (e.g. connect regional HIOs, Direct Project)	• % of eligible providers and hospitals meeting Meaningful Use	• Statewide EHR adoption • Statewide HIE participation • OHA roll-up: Medication errors, duplicate testing	
Meta: **CCO**	Incorporate OHA-recognized PCPCHs into CCO network	• Member experience of care coordination (e.g. shared decision making composite) • % members with individual care plan	• Rate of ambulatory care-sensitive hospital admissions • Member experience of care overall	Better health, lower costs
	Support clinical information exchange among CCO providers (e.g. act as or participate in regional HIO; use Direct)	• Medication management - % members with medications reconciled within 7 days of hospital discharge	• Medication errors • Duplicate testing	Better care
Micro: **Practice or Provider**	Implement PCPCH standards, seek recognition	• % members assigned to personal provider or team	• Benchmark for continuity of care	Better care
	Identify, track and proactively manage patient care electronically using up-to-date information	• Screening for depression and follow-up plan	• % patients showing improvement on clinically valid depression tool	Better care, lower costs

Collected by OHA

EXAMPLES

HB 3650 Section 16: Update on Medical Liability Studies

January 2012

OREGON HEALTH POLICY & RESEARCH

Section 16 Requirements

Section 16 of the Transformation Bill (HB 3650, 2011) requires that the Oregon Health Authority (OHA) conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures, while protecting access to health care services for those in need and protecting their access to seek redress through the judicial system for harms caused by medical malpractice.

Specific Requirements

Specifically, Section 16 directs OHA to explore the costs, benefits and impacts of defensive medicine and several types of medical liability reform options:

- Legislative and administrative remedies
- Caps on damages
- Medical panels
- Extension of the Tort Claims Act to Medicaid
- Joint and several liability options

Four Components of Work

- **Defensive medicine and overutilization studies** – Studying the practice of defensive medicine in Oregon health care and potential savings from reducing the practice.
- **Medical liability policy analysis** – Assessing the benefits and potential impacts of liability reform options and applicability to the Oregon marketplace.
- **Legal analysis** – Exploring the legal and constitutional issues of different medical liability reform options in Oregon.
- **Stakeholder input** – Soliciting stakeholder groups for the best sources of information and research on medical liability reform options in the Oregon marketplace.

Consultants, Internal Experts, Stakeholders

The OHA procured expert consultants, worked with internal experts, and solicited input from several stakeholder groups:

- **Bill Wright, Ph.D., at Providence Center for Outcomes Research and Kate Baicker, Ph.D., from the Harvard School of Public Health** completed the studies on defensive medicine and overutilization, which included a survey of Oregon medical providers addressing the practice of defensive medicine and an analysis of Oregon medical claims.
- **Allen Kachalia, M.D., J.D., and Michelle Mello, J.D., Ph.D., from the Harvard School of Public Health** completed the policy studies that included a thorough literature review and case studies while incorporating Oregon-specific analyses where available to outline the benefits and impacts of reform options.
- **The Oregon Department of Justice** completed a legal analysis of reform options in the Oregon Marketplace to identify any constitutional limitations and to clarify stark laws and their possible affect on CCOs.
- **The Oregon Health Authority** solicited input from several Oregon stakeholder organizations on information and ideas for reform options.

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Medical Liability Policy Analysis

Allen Kachalia, M.D., J.D., and Michelle Mello, J.D., Ph.D., Harvard School of Public Health

- **Deliverable**

  Identify the benefits, costs, and impacts of potential reform options

  1. Caps on noneconomic damages
  2. Medical panels (aka pre-trial screening panels)
  3. Limited Oregon Tort Claims Act (OTCA) coverage extension
  4. Joint-and-several liability (JSL) reform law expansion
  5. Administrative compensation system

- **Approach**
  - Critically reviewed and synthesized existing empirical studies
  - Where possible, modeled effects in Oregon using (1) study findings about effect sizes and (2) data on Oregon malpractice claims, insurance premiums, and health care
  - Considered issues/evidence from stakeholder input

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Key Findings: Medical Liability Policy Analysis

- Noneconomic damages caps may bring cost savings, but likely modest, and carry risk of exacerbating inequities in awards.
- Evidence on medical panels indicates likely no tangible liability benefits and may increase litigation costs or lengthen resolution.
- OTCA extension to providers of Medicaid CCO patients likely of little liability benefit because of small number of patients and how insurance is priced. Also, likely additional cost to the state to implement and fund OTCA extension.
- JSL reform to aid CCOs offers little benefits because most providers carry insurance and settlements are almost always under policy limits; will not address claim reporting concerns for providers.
- ACS offers the greatest prospect for transformative change - but with political and legal challenges.

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Defensive Medicine/Overutilization

Bill Wright, Ph.D., Providence Center for Outcomes Research
Kate Baicker, Ph.D., Harvard School of Public Health

- **Deliverable**
  Use Oregon-specific data to estimate frequency and costs of defensive medicine in Oregon with identification of cost drivers.

- **Study Methodology**
  - Analysis of Oregon health care expenditures data.
  - Surveys to Oregon medical providers to determine how often they order tests or care that are not clinically indicated. To generate scientifically valid estimates and assess survey framing effects, two surveys were used:
    - Some physicians received a survey on "defensive medicine."
    - Others received identical questions, but on a "cost containment" survey.

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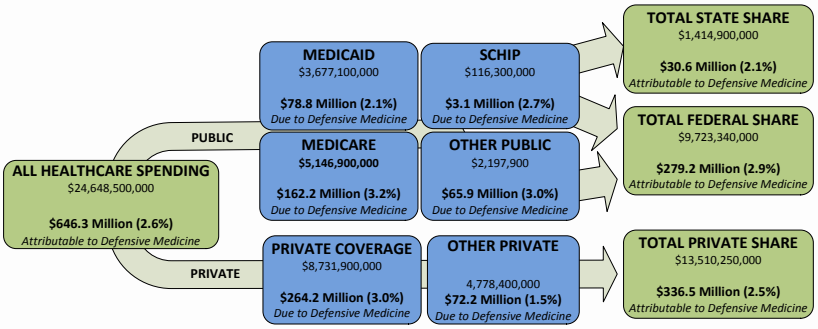
Defensive Medicine/Overutilization, *Cont…*

ANALYSIS OF HEALTHCARE EXPENDITURES DATA

Key Finding #1: Approx $650 million in total OR healthcare spending may be attributable of defensive medicine (2.6% of total expenditures). Most is private or federal spending; the direct impact on Oregon's budget is about $30 million.



BOTTOM LINE: Defensive medicine costs are about $646 Million across the entire Oregon economy. Direct costs to the Oregon budget are about $30 million.

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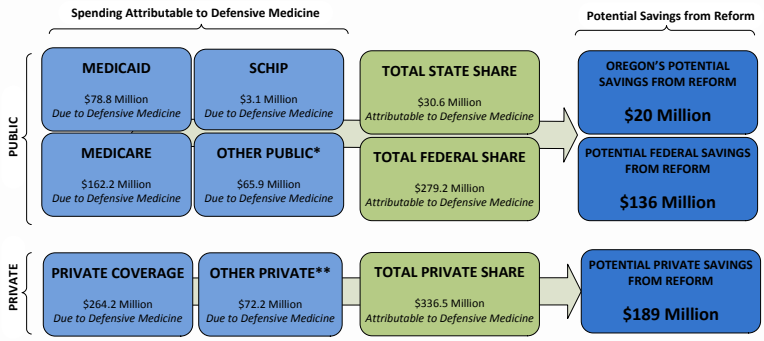
Defensive Medicine/Overutilization, *Cont…*

ANALYSIS OF HEALTHCARE EXPENDITURES DATA

Key Finding #2: The best available estimates on the potential savings of reforms suggest that direct reforms (damage caps) might reduce total OR health expenditures by 1.4%. This would translate into savings of about $20 million in the Oregon budget.



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Defensive Medicine/Overutilization, *Cont…*

ANALYSIS OF PHYSICIAN SURVEY DATA

Key Finding #3: Physician surveys suggest that 14% of the care in four key service types is "medically unnecessary." Unnecessary hospital care accounts for the bulk of costs associated with overutilization.

Type of Service	Overutilization Rate	Associated Costs	Percent of Associated Costs
Imaging (X-Rays, CT scans, MRI, Ultrasounds)	16.2%	$141.0 M	19%
Laboratory Tests (CBC, Chem profile, etc)	13.9%	$24.5 M	3%
Specialist referrals or consults	17.2%	$27.3 M	4%
Hospital admissions	8.2%	$552.7 M	74%
TOTAL OVERUTILIZATION & COSTS	13.9%	$745.6 M	100%

Survey estimate: $745 M in expenditures from unnecessary care (3% of all spending).
Claims data estimate: $646 M from defensive medicine (2.6% of all spending).

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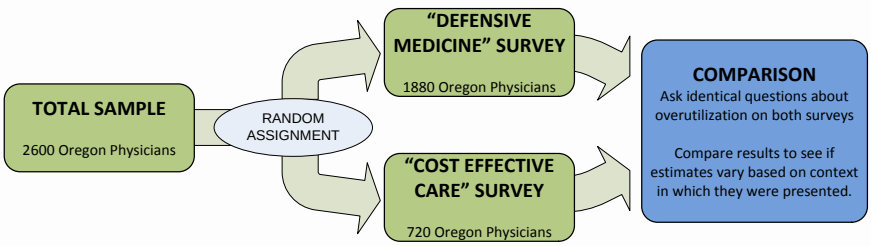
Defensive Medicine/Overutilization, *Cont…*

ANALYSIS OF PHYSICIAN SURVEY DATA

Subjectivity in survey estimates of defensive practice is a real risk. An experimental approach was used to assess the reliability of our survey estimates.



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Defensive Medicine/Overutilization, *Cont…*

ANALYSIS OF PHYSICIAN SURVEY DATA

Key Finding #4: Results of our experimental approach suggest that our approach to estimating overutilization provided scientifically reliable data.

TYPE OF PROCEDURE	PERCENT OF TOTAL ORDERS DEEMED UNNECESSARY BY THE ORDERING PHYSICIAN: OR Physicians on a COST EFFECTIVENESS survey	OR Physicians on a DEFENSIVE MEDICINE survey
X-Rays	15%	15%
CT Scans	15%	19%
MRI Studies	19%	20%
Ultrasound studies	14%	15%
Laboratory Tests (CBC, Chem profile, etc)	14%	14%
Specialist referrals or consults	13%	17%
Hospital admissions	7%	8%
GLOBAL OVERUTILIZATION RATE (includes all of the above)	14%	14%

★ Differences in results were not statistically significant (p<.05, two-tailed chi-square tests)

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Legal Analysis Under Oregon Law

Prepared by the Oregon Department of Justice (DOJ)

- **Deliverable**
  Complete a legal analysis of reform options in the Oregon Marketplace to identify any constitutional limitations and to clarify Stark laws and their possible affect on CCOs.
- **Study Methodology**
  - Worked with the OHA and consultants to coordinate the need for specific legal analyses for each medical liability reform option referred to in Section 16 of HB 3650.
  - Completed an in-depth review of relevant case law on reform options.
  - Completed a legal analysis on Stark laws and other financial interest laws.

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Key Findings from Dept. of Justice Analyses:

Stark Law and Related Limitations on Financial Interests

Stark laws and related financial interest laws can impose legal constraints on some health care arrangements, but help reduce costs.

- Stark law prohibits providers from making referrals for health care services to entities in which the provider has a financial relationship; exemptions exist.
- Anti-kickback laws prohibit payments for referrals; exemptions similar to Stark.
- False claims law imposes civil liability for false or fraudulent claims which can be supported by Stark law violations.

Legal Analysis of Medical Liability Reform Options

- Extension of the Oregon Tort Claims Act must be funded or made conditional.
- Caps on damages would require a change to Oregon's constitution.
- CCOs potentially held vicariously liable for the actions of apparent agents.
- Mandatory and binding medical panels violate Oregon's jury trial provision.
- Administrative Compensation Systems do not violate Oregon's jury trial provision and should survive a challenge that they are *facially* invalid under Oregon's remedy clause.

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Oregon Health Care Workforce Committee

Draft Recommendations from:

1. Workgroup on workforce models for new systems of care
2. Subcommittee on Non-Traditional Health Workers

Oregon Health Policy Board Meeting
January 10, 2012

Oregon Health Authority

Workforce Committee Charter

Recruit Educate Retain

A quality health care workforce to meet the demand created by expansion in health insurance coverage, system transformation and an increasingly diverse population

- Coordinate efforts to meet demand
- Develop recommendations & action plans for OHPB

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Workforce/ Staffing Models for New Systems of Care

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Workforce for New Models of Care

OHPB Request:

- Describe promising staffing models and/or workforce roles for CCOs, PCPCHs, or similar integrated, coordinated service delivery organizations
- Identify health care workforce competencies required to implement promising models
- Recommend actions to build those competencies within Oregon's health care workforce

Process:

- Reviewed the existing literature / recommendations from national bodies
- Conducted key informant interviews with 30+ healthcare professionals, educators, health system administrators, and policy experts in Oregon
- Analysis & development of recommendations in consultation with Committee

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Key Message - Workforce for New Models of Care

Interprofessional team-based care is the optimal model for integrated and coordinated health care

"When multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care" (WHO, 2010)

- Interprofessional team-based care enables the processes and outcomes that CCOs and PCPCHs are intended to achieve: comprehensive, integrated, whole-person care, improved efficiency, and better patient health
- Oregon expert: "*A strong primary care foundation is essential for an effective health care system…The Patient Centered Primary Care Home is now widely recognized as the model for strengthening primary care. It requires an interdisciplinary team.*"

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Competencies - Workforce for New Models of Care

Individual competencies for interprofessional team care:

- Communication (interprofessional and provider to client & family)
- Cultural competency
- Roles & responsibilities for collaborative practice, teamwork
- Leadership and change management
- Computer literacy, HIT, and use of data for population care management

Organizational competencies for interprofessional team care:

- Flexible reimbursement mechanisms
- Supportive workplace culture – egalitarian & collaborative
- Operational infrastructure – methods for team formation and division of labor, IT systems, and timely data on clients' care and health status
- Community engagement

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Recommendations - Workforce for New Models of Care

Policy recommendations:

- Establish / expand pilot programs to test alternative payment models
- Develop job descriptions for new positions such as care coordinators, navigators, community health workers, etc.
- Provide opportunities for multi-payer alignment around promising alternative models of reimbursement
- Revise job descriptions for existing categories of health care workers to reflect the nature of inter-professional, team-based care

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Recommendations - Workforce for New Models of Care

Education recommendations:

- Develop shared methods for training and assessment of interprofessional competencies.
- Provide opportunities for faculty to gain experience with interprofessional practice and new models of care.
- Increase opportunities for interprofessional training, especially in clinical settings
- Set expectations for collaboration between education communities and health care employers
- Collaborate across disciplinary boundaries to develop and implement the same set of interprofessional competencies

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Recommendations - Workforce for New Models of Care

Practice recommendations :

- Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices.
- Identify successful early adopters of team-based care models to assist practices with transition.
- Prioritize investment in information technology infrastructure.
- Revise hiring and human resources practices to enable recruitment, retention, and evaluation of professionals engaged in interprofessional and team-based care.

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Next steps? - Workforce for New Models of Care

- Public and stakeholder feedback
- Potential online survey or other mechanism to collect input on substance of recommendations as well as best steps/venues for implementing recommendations, targeting:
  - Health care employers and system administrators
  - Practicing educators and trainers
  - Consumers

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Roles, Competencies and Training for Non-Traditional Health Workers

Oregon Health Authority

Charge – Non-Traditional Health Workers

HB 3650 Section 11 :

(1) The Oregon Health Authority, in consultation with the appropriate health professional regulatory boards as defined in ORS 676.160 and advocacy groups, shall develop and establish with respect to community health workers, personal health navigators, peer wellness specialists and other health care workers who are not regulated or certified by this state:

- (a) The criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and
- (b) Education and training requirements for such individuals.

(2) The criteria and requirements established under subsection (1) of this section:

- (a) Must be broad enough to encompass the potential unique needs of any coordinated care organization;
- (b) Must meet requirements of the Centers for Medicare and Medicaid Services to qualify for federal financial participation; and
- (c) May not require certification by the Home Care Commission.

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Subcommittee – Non-Traditional Health Workers

Members represent health systems, insurers, educational institutions, behavioral health and addictions recovery programs, community clinics, social service and advocacy organizations, and practicing non-traditional health workers from the field.

Process of building draft recommendations included:

- Review of state and national research, existing legislation, published recommendations, and current NTHW programs
- Survey of currently practicing self-identified NTHWs in Oregon, resulting in 620 responses
- Description of scope of work for NTHWs in Oregon → identification of competencies needed to fulfill that scope → recommendations for training aligned with competencies
- Recommendations for certification and oversight

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Scope of work – Non-Traditional Health Workers

1. Outreach and Mobilization

   Provision of health-related information, resources, and services to ensure that individuals and their natural support systems are informed and able to take action

2. Community and Cultural Liaising

   Supporting connections among individuals, families, community members, organizations and leaders, providers, and health systems to effectively bridge cultural, health belief, linguistic, geographic and structural differences that limit individuals' ability to access health care or adopt health promoting behaviors

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Scope of work – Non-Traditional Health Workers

3. Case Management, Care Coordination, & System Navigation

   Collaborative process of assessment, planning, facilitation and advocacy to help people evaluate options and access services in order to meet their holistic health needs through available resources in a timely, efficient and culturally appropriate manner

4. Health Promotion and Coaching

   The process of enabling people to increase control over their health and its determinants, and thereby improve their health; includes assisting individuals and their identified families to make desired behavioral changes, identifying and enhancing strengths and addressing barriers

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Competencies & Training

Role	Competencies	Training
1. Outreach and Mobilization	• Communicate effectively with individuals and their identified families and community members about individual needs, concerns and assets • Identify and document needs and health topics relevant to the priority population, including common strengths, barriers and challenges • Adapt outreach strategies based on population, venue, behavior or identified risks as appropriate to a given population and its self-determined concerns • Engage individuals and community members in ways that establish trust and rapport with them and their families • Create a non-judgmental atmosphere in interactions with individuals and their identified families • Develop and disseminate culturally and linguistically appropriate information to service population regarding available services and processes to engage in services • Document and help create networks and establish partnerships and linkages with other NTHWs and organizations for the purpose of care coordination and enhancing resources • Support individuals and their identified families and community members to utilize care and community resources • Effectively utilize various education and communication strategies to inform and educate individuals and community members about health, health interventions, and available health services	Core Curriculum: • Outreach Methods • Community Engagement, Outreach and Relationship Building • Communication Skills, including cross-cultural communication, active listening, and group and family dynamics • Empowerment Techniques • Knowledge of Community Resources Additional Required Curriculum for specific worker types, practice settings, or jobs: • Self-Efficacy (Community Health Workers, Peer Wellness Specialists) • Community Organizing (Community Health Workers) • Group Facilitation Skills (Community Health Workers, Peer Wellness Specialists)
2. Community and Cultural Liaising	• Advocate for individuals and their identified families, and community groups/populations • Recognize and define cultural, linguistic, and social differences, such as differing understandings of: family unity, religious beliefs, health-related beliefs and practices, generational differences, traditions, histories, socioeconomic system, refugee and immigration status and government systems • Educate service systems about community needs and perspectives • Build individual and community capacity to support people who seek and receive care by providing information/education on specific health issues and interventions, including identifying and addressing social determinants of health • Recognize conflict and utilize conflict resolution strategies • Conduct individual needs assessments	Core Curriculum: • Cultural Competency/Cross Cultural Relationships • Conflict Identification and Problem Solving • Social Determinants of Health • Conducting Individual Needs Assessments • Advocacy Skills • Building Partnerships with local agencies and groups Additional Required Curriculum for specific worker types, practice settings, or jobs: • Conducting Community Needs Assessments (Community Health Workers)
3. Case Manage-ment, Care Coordin-ation and System Navigation	• Deliver person-centered advocacy • Provide timely and accurate referrals • Work effectively across multidisciplinary teams • Demonstrate and communicate understanding of public and private health and human services systems • Coordinate between multiple providers and systems providing care and services • Assure follow up care and support individual and providers to maintain connections throughout treatment process • Disseminate information to appropriate individuals • Understand and maintain ethical boundaries between self and individual or family being served • Describe individual(s)' rights and confidentiality clearly and appropriately, including informed consent and mandatory reporting requirements • Utilize crisis management techniques • Complete accurate and timely documentation of care processes, including effectively using tools such as computer programs, databases, charts and other documentation materials needed by supervisor/care team • Assist individual (and identified family members as appropriate) to set goals and collaboratively plan specific actions to reach goals • Assist people with paperwork needed to access services • Assist people to access basic needs services (e.g. food, housing, employment, etc.)	Core Curriculum: • The Role of Non-Traditional Health Workers • Roles and Expectations for Working in Multidisciplinary Teams • Ethical Responsibilities • Legal Responsibilities • Paths to Recovery (specific to worker type) • Data Collection and Types of Data • Organization Skills and Documentation • Crisis Identification, Intervention and Problem-Solving • Professional Conduct (including relationship boundaries and maintaining confidentiality) • Navigating public and private health and human service systems (state, regional, local) • Working with caregivers, families, and support systems, including paid care workers
4. Health Promotion and Coaching	• Define and describe basic disease processes including chronic diseases, mental health, and addictions, basic warning signs and symptoms • Define and describe basic dynamics of traumatic issues impacting health, such as child abuse, domestic violence, self harm, and suicide • Motivate individual to engage in behavior change, access needed services and/or advocate for themselves • Provide coaching and support for behavior change (self-management), including responding to questions and/or fears, offering multiple examples of desired changes and potential outcomes, and using appropriate and accessible formats for conveying health information • Collect and apply knowledge of individuals' history and background, including experiences of trauma, to inform health promotion and coaching strategies • Assist individual to set goals and collaboratively plan specific actions to reach goals • Provide informal emotional or psychological support through active listening, paraphrasing and other supportive techniques • Support and empower individuals to choose from treatment options where available and support adherence to treatment choice	Core Curriculum: • Introduction to Disease Processes including chronic diseases, mental health, and addictions (warning signs, basic symptoms, when to seek medical help) • Trauma-Informed Care (screening and assessment, recovery from trauma, minimizing re-traumatization) • Health Across the Life Span • Adult Learning Principles – Teaching and Coaching • Stages of Change • Health Promotion Best Practices • Self-Care • Health Literacy Issues Additional Required Curriculum for specific worker types, practice settings, or jobs: • Popular Education Methods (Community Health Workers) • Cultivating Individual Resilience (Peer Wellness Specialists) • Recovery Model (Peer Wellness Specialists) • Healthcare Best Practices (specific to fields of practice) • Wellness within a specific disease (Personal Health Navigator) • Basic health screenings (e.g. blood pressure measurement)

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Certification – Non-Traditional Health Workers

Goals of certification:

- Clarify NTHW role
- Facilitate optimal integration of NTHWs by health care providers
- Bolster sustainable funding options, including reimbursement through Medicaid and Medicare
- Promote recognition of the value of NTHWs
- Highlight options for individual development along health care career paths

Certification must not:

- Exclude currently practicing NTHWs from their own field
- Create unreasonable barriers for new NTHWs to enter the field
- Discourage the use of holistic and culturally based approaches key to reducing health disparities and promoting health equity

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Certification – Non-Traditional Health Workers

Subcommittee recommends a two-part process:

1. Central body reviews and approves competency-based training programs
2. Programs provide individuals with certificate of completion; OHA requires that certification for enrollment as Medicaid provider

Training:

- Exact number of hours still under discussion (working recommendation is min. 80 didactic or on-the-job training, with additional hours for supplemental training specific to worker types, practice settings, or jobs)
- “Grandparent” currently practicing NTHWs who also participate in an incumbent worker training. Number of practice years required for "grandparenting" TBD; may differ by worker type due to length of time that job categories have been in existence
- Limit the cost of enrolling in training programs for NTHWs

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Certification – Non-Traditional Health Workers (2)

Training Oversight:

- Establish or assign oversight for training programs to central body. This entity would:
  - Review and approve training programs and educational methodologies
  - Maintain a registry and/or certification records, including ethics violations
  - Promote NTHW professions, including educating health care providers and systems on the effective utilization of NTHWs
- Entity should convene an advisory body to provide T.A. and feedback to training programs to ensure continuous improvement and comparability of training for job mobility. The advisory body should include experienced NTHWs in numbers sufficient to maintain integrity of the NTHW model(s).
- Review and renew training programs every 3 years to ensure quality, relevance and compliance with curriculum requirements, educational standards, and expected performance outcomes for workers

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Certification – Non-Traditional Health Workers (3)

Additional Recommendations:

- Require supervision of NTHWs by licensed health care professionals, licensed behavioral health professionals, or Masters level public health workers
- Provide incentives for CCOs to develop internal agency plans for the supervision and support of NTHWs, including developing strategies within the global budget to support training and retention of NTHWs on health care teams
- Develop strategies for all training partners to assess the needs of NTHWs for continuing education, to design and develop programs to meet those needs, and to implement and evaluate programs on an ongoing basis

Oregon Health Authority

Oregon Health Authority

COMMON Competency and training recommendations for NTHWs, by role

Community Health Workers (CHW), Peer Wellness Specialists (PWS), and Personal Health Navigators (PHNav)

(See following table for training recommendations specific to worker type)

Role	Core Competencies	Core Training Elements
1. Outreach and Mobilization	• Communicate effectively with individuals and their identified families and community members about individual needs, concerns and assets • Identify and document needs and health topics relevant to the priority population, including common strengths, barriers and challenges • Adapt outreach strategies based on population, venue, behavior or identified risks as appropriate to a given population and its self-determined concerns • Engage individuals and community members in ways that establish trust and rapport with them and their families • Create a non-judgmental atmosphere in interactions with individuals and their identified families • Develop and disseminate culturally and linguistically appropriate information to service population regarding available services and processes to engage in services • Document and help create networks and establish partnerships and linkages with other NTHWs and organizations for the purpose of care coordination, prevention or harm reduction, and enhancing resources • Support individuals and their identified families and community members to utilize care and community resources • Effectively utilize various education and communication strategies to inform and educate individuals and community members about health, health interventions, and available health supports and services	• Outreach Methods • Community Engagement, Outreach and Relationship Building • Communication Skills, including cross-cultural communication, active listening, and group and family dynamics • Empowerment Techniques • Knowledge of Community Resources
2. Community and Cultural Liaising	• Advocate for individuals and their identified families, and community groups/populations • Recognize and define cultural, linguistic, and social differences, such as differing understandings of: family unity, religious beliefs, health-related beliefs and practices, generational differences, traditions, histories, socioeconomic system, refugee and immigration status and government systems • Educate care teams & service systems about community needs and perspectives • Build individual, clinical team, and community capacity to support people who seek and receive care by providing information/education on specific health issues and interventions, including identifying and addressing social determinants of health • Recognize conflict and utilize conflict resolution strategies • Conduct individual needs assessments	• Cultural Competency/Cross Cultural Relationships, including bridging clinical and community cultures • Conflict Identification and Problem Solving • Social Determinants of Health • Conducting individual Needs Assessments • Advocacy Skills • Building Partnerships with local agencies and groups

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Role	Core Competencies	Core Training Elements
3. Case Management, Care Coordination and System Navigation	• Deliver person-centered information and advocacy • Provide timely and accurate referrals • Work effectively across multidisciplinary teams • Demonstrate and communicate understanding of public and private health and human services systems • Coordinate between providers, teams and systems providing care & services • Assure follow up care and support individual and providers to maintain connections throughout treatment process • Disseminate information to appropriate individuals • Understand and maintain ethical boundaries between self and individual or family being served • Describe individual(s)' rights and confidentiality clearly and appropriately, including informed consent and mandatory reporting requirements • Utilize crisis management techniques • Complete accurate and timely documentation of care processes, including effectively using tools such as computer programs, databases, charts and other documentation materials needed by supervisor/care team • Assist individual (and identified family members as appropriate) to set goals and collaboratively plan specific actions to reach goals • Assist people with paperwork needed to access services • Assist people to access basic needs services (e.g. food, housing, employment, etc.)	• The Role of Non-Traditional Health Workers • Roles and Expectations for Working in Multidisciplinary Teams • Ethical Responsibilities in a multicultural context • Legal Responsibilities • Paths to Recovery (specific to worker type) • Data Collection and Types of Data • Organization Skills and Documentation, including use of HIT • Crisis Identification, Intervention and Problem-Solving • Professional Conduct (including culturally appropriate relationship boundaries and maintaining confidentiality) • Navigating public and private health and human service systems (state, regional, local) • Working with caregivers, families, and support systems, including paid care workers
4. Health Promotion and Coaching	• Define and describe basic disease processes including chronic diseases, mental health, and addictions, basic warning signs and symptoms • Define and describe basic dynamics of traumatic issues impacting health, such as historical and cultural trauma, child abuse, domestic violence, self harm, and suicide • Motivate individual to engage in behavior change, access needed services and/or advocate for themselves • Provide coaching and support for behavior change (self-management), including responding to questions and/or fears, offering multiple examples of desired changes and potential outcomes, and using appropriate and accessible formats for conveying health information • Collect and apply knowledge of individuals' history and background, including experiences of trauma, to inform health promotion and coaching strategies • Assist individual to set goals and collaboratively plan specific actions to reach goals • Provide informal emotional or psychological support through active listening, paraphrasing and other supportive techniques • Support and empower individuals to choose from treatment options where available and support adherence to treatment choice	• Introduction to Disease Processes including chronic diseases, mental health, and addictions (warning signs, basic symptoms, when to seek medical help) • Trauma-Informed Care (screening and assessment, recovery from trauma, minimizing re-traumatization) • Health Across the Life Span • Adult Learning Principles - Teaching and Coaching • Stages of Change • Health Promotion Best Practices • Self-Care • Health Literacy Issues

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Training recommendations specific to NTHW type

CHW = Community Health Worker, PWS = Peer Wellness Specialist, PH Nav. = Personal Health Navigator

Role	Supplemental Training Elements	CHW	PWS	PH Nav.
1. Outreach and Mobilization	Self-Efficacy	X	X	
	Community Organizing	X		
	Group Facilitation Skills	X	X	
2. Community and Cultural Liaising	Conducting Community Needs Assessments	X		
3. Case Management, Care Coordination and System Navigation	*No training elements recommended beyond core that applies to all three worker types*			
4. Health Promotion and Coaching	Popular Education Methods (Community Health Workers)	X		
	Cultivating Individual Resilience (Peer Wellness Specialists)		X	
	Recovery Model (Peer Wellness Specialists)		X	
	Healthcare Best Practices (specific to fields of practice)	X (specific to field of practice)	X (specific to field of practice)	X (specific to field of practice)
	Wellness within a specific disease (Personal Health Navigator)			X
	Basic health screenings (e.g. blood pressure measurement)	X (specific to job role)		
	Motivational interviewing	X	X	

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By Christine T. Kovner, Sean P. Corcoran, and Carol S. Brewer

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The Relative Geographic Immobility Of New Registered Nurses Calls For New Strategies To Augment That Workforce

ABSTRACT Little is known about registered nurses' geographic mobility after they earn their first professional degree and become licensed to practice. Through a cross-sectional mailed survey of newly licensed registered nurses in fifteen states, we found that 52.5 percent work within forty miles of where they attended high school. Our complementary analysis of Census Bureau data shows that next to teaching, nursing is one of the least mobile professions for women, for reasons that remain unclear. To ensure that underserved areas have an adequate workforce of registered nurses, policy makers should expand the number of educational programs in these areas; fund programs that provide incentives to young people from these areas to attend nursing programs; consider supporting extension programs from accredited nursing schools; and review admission policies for nursing programs and the financial aid they offer. If states find it difficult to retain out-of-state graduates, giving preference to in-state applicants may make sense. Finally, programs and policies that offer financial incentives to attract registered nurses to underserved areas, such as the National Health Service Corps and the Area Health Education Centers, are critically important. When sufficiently funded, such programs could serve to offset the low mobility of new registered nurses that we observed.

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Research on the long-term supply of registered nurses (RNs) has focused on several key determinants of supply, including the cost, type, and availability of registered nurse education programs,[1] cohort size,[2] relative earning opportunities,[3] immigration,[4] and changing preferences for careers in nursing.[5] However, few studies have examined the geography of RN labor markets. The extent to which registered nurses are geographically mobile shapes the long-term supply of registered nurses in each local market, which affects the hiring decisions of health care employers. This has important implications for policy and workforce planning.

Research on labor-market geography in health care is sparse and focuses more on physicians than on nurses. Work by Jack Ladinsky in the late 1960s identified key factors associated with the mobility of professional workers.[6] The least mobile professions were those that required heavy capital investment or the cultivation of long-term client relationships, or those with restrictive state licensing arrangements—as is the case with lawyers and dentists, for example. High-mobility professions tended to be those that exhibited a flat organizational hierarchy, with few opportunities for vertical advancement, as in academe.

According to these indicators, nursing should be a moderately mobile profession. Although upward mobility is possible in many health care

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organizations, and registered nurses are licensed to practice in one state, because of agreements such as the National Council of State Boards of Nursing interstate nurse licensure compact,[7,8] it is not difficult for a registered nurse to obtain a license in another state.

The availability of higher education programs also influences people's mobility, because graduates in general tend to remain in the same region as their degree program.[9] In nursing, two- and four-year educational programs are less geographically concentrated than is the case in other professions—including medicine, dentistry, and law. This makes it more likely that registered nurses will be trained and accept employment closer to home, compared to professionals in other fields.

In the physician labor market, studies in Australia, New Zealand, and the United States have found that physicians raised in rural areas were more likely to practice in those areas, even when trained elsewhere.[10–12] In England, 38 percent of physicians attended medical school in the same region as their family home, and a similar share ultimately practiced in the same region.[13] In nursing, researchers found that 87 percent of Canadian RNs remained in the same province in which they had been trained.[14] Fully 64 percent of early-career nurses tracked in a longitudinal study in England remained in the region in which they had been trained.[15]

Much less is known about the mobility of registered nurses in the United States. We used a cross-sectional survey of newly licensed RNs to examine the extent to which they remain "close to home" in their choice of training programs and jobs.

Study Data And Methods

We used data from a cross-sectional survey of 1,765 registered nurses who passed the National Council Licensing Examination between August 1, 2007, and July 31, 2008. The survey was based on an existing instrument that we used in a larger, ongoing longitudinal study of newly licensed registered nurses.[16] We mailed the survey to the sample group in early 2009, including a $5 incentive to complete it. We sent up to four additional mailings to members of the group who did not respond. We estimate a response rate of 58 percent.[17,18]

Our sampling strategy was a stratified random selection of Metropolitan Statistical Areas and rural areas to reflect the entire US population.[16] For the analysis reported here, we chose a random sample of registered nurses from the stratified sample of Metropolitan Statistical Areas and rural areas in the fifteen states whose licensing boards could readily provide contact information for first-time registered nurses licensed by examination during the study period (Alabama, Kentucky, Maryland, Michigan, Nevada, New Jersey, New York, North Carolina, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and West Virginia). Although this sample is not nationally representative, it is geographically diverse.

METHODS Our survey is unique in that it asked respondents to provide the city and state for all educational programs from which they had gotten a degree or diploma—including high school diplomas and degree programs in nursing and other fields—as well as the ZIP codes of their primary workplace and home. With these data, we were able to use Geographic Information Systems software to calculate the approximate distance between the registered nurses' high school (a proxy for where they grew up), their first nursing degree program, and their current job. (We excluded from our analysis 130 respondents who had attended high school outside the United States.)

We calculated the straight-line distance in miles between each pair of locations, as follows: high school and degree program, degree program and workplace, and high school and workplace. Respondents typically identified their current job location by ZIP code. However, they identified most high schools and degree programs by city and state. When we had no ZIP code, we calculated the straight-line distance between the centroids of two cities or towns.[19] Respondents who had attended a nursing program in the same city where they had gone to high school were assigned a distance of zero miles, if no ZIP code was provided.

To determine whether or not the geographic mobility in our sample was typical for professional workers in general, and early-career professional women in particular, we turned to a 5 percent household sample of the 2000 census (the Integrated Public Use Microdata Series).[20] From this nationally representative sample, we extracted all people ages 18–64 (nearly 9.7 million people), focusing primarily on those born in the United States and reporting an occupation. This group included roughly 129,000 self-identified registered nurses, 93.1 percent of whom were women.[21] Although the Census Bureau does not collect information about people's past school locations, it does collect state of birth. Using this variable, we calculated the percentage of all adults and of women ages 20–39 currently residing in their state of birth, by occupational category. We then compared the mobility of registered nurses to this benchmark.

SAMPLE Although our sample was drawn from

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fifteen states, 50 percent of respondents were employed in one of four states: New York (15.9 percent), North Carolina (14.0 percent), Texas (11.5 percent), and New Jersey (8.5 percent). However, census data show that these states have some of the largest numbers of working registered nurses and that together they contain 19.8 percent of RNs under age thirty-five.

The characteristics of our sample are shown in Exhibit 1. A majority of the respondents (54.7 percent) received an associate's degree as their first professional degree in nursing. Almost 80 percent of the respondents were white, 56 percent were married, 45 percent had children living at home, and 90 percent were working in a hospital setting. Notably, the educational attainment of our sample was quite similar to the data presented in our study of registered nurses licensed in 2004–05[16] and a recent report on new RNs by the National Council of the State Boards of Nursing.[22]

Nearly all of the respondents provided sufficient information for us to identify the geographic location of their home (99.9 percent) and workplace (94.8 percent), and almost 80 percent reported the location of their high school.[23] Depending on the degree type, 89–96 percent provided the location of their degree program. In almost all cases, locations were precise up to the city (or town); where respondents provided ZIP codes, we were able to be more precise. Although our full sample included 1,765 registered nurses, the results that we present below include only those respondents whose locations could be geocoded.

LIMITATIONS There are several limitations to our survey findings. The findings are limited to recent graduates, and longer time horizons may show greater mobility. Although our data came from 30 percent of US states, the findings are not nationally representative. Registered nurses from urban areas tended to be overrepresented in our sample, with only a small number located in rural areas. Some states may be net importers of registered nurses, while others may be net exporters. In addition, the findings are based on self-reported locations, which are subject to error. Response bias is also a potential problem: Those registered nurses who did not respond might have relocated and not have received the survey.

Study Results

GEOGRAPHIC MOBILITY OF NEWLY LICENSED REGISTERED NURSES We began by examining RNs' mobility between states. The vast majority of newly licensed registered nurses in our sample (approximately 79 percent) attended their first nursing degree program in the state in which they graduated from high school. This fraction was slightly smaller for the subset of registered nurses whose first degree in nursing was a bachelor's degree (data not shown but available on request).

Approximately 88 percent of the registered nurses in our sample took their first RN job in the state where they received their first nursing degree, a proportion only marginally smaller for the subset of those with a bachelor's degree (84.6 percent). A large fraction of newly licensed RNs reported working in the same state where they had attended high school—78.7 percent and 76.8 percent for associate's and bachelor's degree recipients, respectively.

Our analysis of distance found that registered nurse labor markets were even more local than the results described above suggest. Exhibit 2 summarizes the straight-line distances between early-career nurses' high school and first nursing degree program, first program and current workplace, and high school and current workplace. Distributions for the distance between high school and workplace are illustrated in Exhibit 3.

EXHIBIT 1

Characteristics Of Registered Nurses Graduating In 2007–08

Characteristic	Percent or mean	Number
Full sample	100.0%	1,765
Age (mean years)	32.5	1,731
Female	90.7%	1,588
RACE/ETHNICITY		
White	79.4%	1,387
Black	11.2	196
Asian/Pacific Islander	6.1	106
MARITAL AND FAMILY STATUS		
Married	55.5	971
Never married	36.0	631
Children living at home	45.0	787
Children age 6 or younger living at home	20.4	357
CURRENT AREA OF RESIDENCE		
Metropolitan area (population 50,000 or more)	88.6	1,497
Micropolitan area (population 10,000–49,000)	8.8	148
Small town or rural area (population under 10,000)	2.6	44
EMPLOYMENT STATUS		
Currently employed	95.1	1,679
Employed in a hospital	89.1[a]	1,496
Employed in a nursing home	3.3[a]	56
FIRST PROFESSIONAL NURSING DEGREE		
Associate's degree	54.7	939
Bachelor's degree	38.3	658
Nursing diploma	7.0	121

SOURCE Authors' cross-sectional survey of registered nurses licensed in 2007–08 in fifteen states. **NOTE** We did not include all categories of characteristics (such as "other" for race/ethnicity), so not all percentages sum to 100. [a]Percent of employed registered nurses.

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EXHIBIT 2

Geographic Mobility Of Registered Nurses Graduating In 2007–08, By Type Of Mobility Observed And Type Of Nursing Degree First Attained

	Distance (number of miles)				Distance, miles (%)				
First degree	Mean	Median	25th percentile	75th percentile	0–15	15–<40	40–<100	100+	Number of nurses
DISTANCE BETWEEN HIGH SCHOOL AND DEGREE PROGRAM									
Associate's degree	196.5	25.3	8.3	153.5	38.7	19.3	10.6	31.5	784
Bachelor's degree	206.6	54.2	14.0	177.0	26.9	17.8	17.9	37.4	529
Nursing diploma	134.3	16.8	3.4	89.9	47.8	21.7	7.6	22.8	92
All degrees	197.6	31.6	9.9	167.2	34.7	18.8	13.3	33.2	1,405
DISTANCE BETWEEN DEGREE PROGRAM AND WORKPLACE									
Associate's degree	125.9	18.8	5.5	72.8	45.9	20.9	10.9	22.3	895
Bachelor's degree	161.6	26.6	5.7	143.0	40.2	15.3	14.9	29.7	598
Nursing diploma	131.7	16.9	6.2	62.7	46.6	18.5	17.5	17.5	103
All degrees	138.2	21.3	5.6	98.7	43.7	18.6	12.9	24.8	1,596
DISTANCE BETWEEN HIGH SCHOOL AND WORKPLACE									
Associate's degree	198.5	29.0	8.6	176.3	36.7	18.0	11.9	33.4	768
Bachelor's degree	232.0	39.8	10.0	179.9	31.8	18.0	13.6	36.7	513
Nursing diploma	160.4	34.0	9.2	136.8	40.8	10.2	20.4	28.6	98
All degrees	209.5	31.1	9.2	176.0	35.1	17.4	13.2	34.3	1,379

SOURCE Authors' cross-sectional survey of registered nurses licensed in 2007–08 in fifteen states. **NOTES** Excludes registered nurses attending high school or any degree program outside the United States. Percentages might not sum to 100 because of rounding.

A large proportion of registered nurses chose a training program and a job quite close to where they attended high school (Exhibits 2 and 3). For example, the median distance between degree program and high school was 31.6 miles. The median distance between degree program and workplace was smaller still, only 21.3 miles. In all cases, the mean distance was much larger than the median, reflecting the influence of a few long-distance moves.

Approximately two-thirds of the registered nurses in our sample were working within 100 miles of where they grew up, and 35.1 percent were working within 15 miles of where they had attended high school. The likelihood of working close to home was larger for those whose first nursing degree was a diploma or an associate's degree than for those whose first degree was a bachelor's degree (Exhibit 3). In the next section we put these results in context, examining whether mobility among registered nurses is comparable to that among professional workers in general.

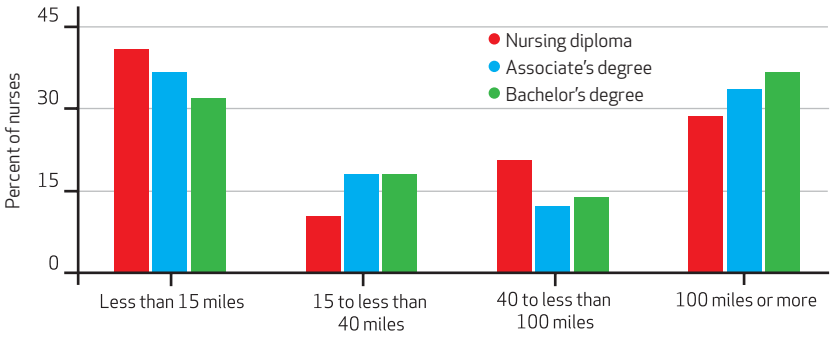
As noted above, half of our sample had been licensed in one of four states: New York, North Carolina, Texas, and New Jersey. It may be that mobility is particularly low in these states, given that three are geographically large and densely populated, and they may offer more job opportunities than are available in other parts of the country.[24] In addition, neither New York nor New Jersey participates in the National Council of State Boards of Nursing nurse licensure compact,[8] which would allow registered nurses to move freely to other states without having to obtain new licenses.

As one robustness check, we replicated our analysis for registered nurses licensed in an earlier year (2004–05) who participated in the longitudinal survey on which this survey was based[16] (data not shown but available on request). That sample was more evenly distributed across states, with the largest concentrations in California (11 percent), North Carolina (6 percent), and Massachusetts (6 percent).

The findings of the two surveys were nearly identical, with a median distance in the earlier survey from high school to degree program of

EXHIBIT 3

Distance From High School To Workplace For Registered Nurses Graduating In 2007–08



SOURCE Authors' cross-sectional survey of registered nurses licensed in 2007–08 in fifteen states.

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Only a small minority of professionals have a greater propensity than RNs to remain in their state of birth.

36.5 miles, a median distance from degree program to workplace of 20.4 miles, and 31.6 percent of all registered nurses working within fifteen miles of where they had attended high school.

GEOGRAPHIC MOBILITY IN VARIOUS PROFESSIONS The fact that newly licensed registered nurses in the United States have limited geographic mobility is useful knowledge for policy makers seeking to increase the supply of RNs in specific locales. It is natural to ask, however, whether geographic immobility is common for professional workers in general, or for early-career professional women in particular. We investigated this question by turning to a 5 percent household sample of the 2000 census.[20]

Census data show that close to two-thirds of native-born adults (63.0 percent) and early-career women ages 20–39 (66.3 percent) were residing in their state of birth at the time of the 2000 census. This rate falls with the level of schooling attained, declining to 60.8 percent for professional workers (as defined by the Census Bureau) with an associate's degree and 53.3 percent of professional workers with a bachelor's degree.

In all categories, women—and early-career women, in particular—were more likely than men to reside in their state of birth. Among early-career professional women, 66.6 percent with associate's degrees lived in their state of birth, as did 57.2 percent of those with bachelor's degrees.

Registered nurses were more likely than other professional workers to be living in their state of birth. Among those with an associate's degree, 61.6 percent of registered nurses were living in their state of birth, compared to 60.5 percent of other professionals.[25] These differences were statistically significant at conventional levels, given the large sample. Among early-career women, the comparable shares were 67.2 percent of registered nurses and 66.4 percent of other professionals ($p = 0.044$).

The differential propensity to be living in one's state of birth was particularly stark for RNs with a bachelor's degree. In this case, 61.6 percent of female registered nurses ages 20–39 with a bachelor's degree were living in their state of birth versus 56.8 percent of comparable professionals in other fields—a difference of 4.7 percentage points ($p < 0.001$).

Another way to put the geographic immobility of registered nurses in context is to look at the fraction of workers with a greater likelihood of remaining in the same state than RNs. We found that only 31.9 percent of professional workers with an associate's degree and 34.3 percent of those with a bachelor's degree were more likely than registered nurses to reside in their state of birth. The majority of those were teachers, who represent about 18 percent of female professionals with a bachelor's degree. When we excluded teachers, only 16.2 percent of professional workers with a bachelor's degree were more likely than registered nurses to reside in their state of birth.[26] When the sample is limited to early-career women ages 20–39, the comparable proportion is 15.0 percent.

Discussion

Our findings suggest that newly licensed registered nurses have limited geographic mobility, implying that nursing labor markets are very local in nature. Our analysis of census data showed that only a small minority of professionals have a greater propensity than RNs to remain in their state of birth, confirming that the nursing profession draws from a relatively local labor force.

The low mobility of new registered nurses has important implications for nursing workforce policy. Health care employers must often rely heavily on locally trained RNs who grew up and attended school in a limited geographic area. This may be of particular concern to employers in rural or other underserved areas, who have limited ability to attract additional registered nurses from elsewhere.

We did not ask the newly licensed registered nurses why they did or did not move. Almost 56 percent were married, and many had small children living at home. The limited geographical mobility might be related to their partners' job commitments or to a preference for living near extended family, especially when raising children.

A lack of geographic mobility might also be related to the unstable economic conditions when these newly licensed registered nurses completed their education. The Census Bureau reported that 11.9 percent of US households moved in 2008 (the lowest rate since 1948, when

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these data were first collected), and the figure rose only slightly, to 12.5 percent, in 2009.[27] Although these statistics could indicate that the absolute geographic mobility reported by the newly licensed registered nurses was lower than in other years, the lack of geographic mobility of RNs relative to other female professionals remains.

To expand the supply of nurses in underserved areas, we recommend four policy changes, each focused on supporting and maintaining local capacity. First, workforce planners should consider targeting educational support—such as scholarships and loan forgiveness programs—to provide incentives to students from the local area to pursue nursing education. These programs could support candidates at nearby universities or could make support conditional on graduates' serving a fixed number of years in the area.

Second, policy makers should expand the number of educational programs in underserved areas. These could take the form of new four-year programs in nursing education or an expanded use of distance learning. The cost of opening new programs is prohibitive in places such as rural areas with declining populations.[28] In these areas, states could create extension programs or expand programs at local community colleges to offer a bachelor's degree in nursing.

Third, state and university leaders should review their admission policies for nursing programs and the financial aid they offer. If states find it difficult to retain out-of-state graduates, giving preference to in-state applicants may make sense—recognizing that colleges must balance these preferences with the need for out-of-state revenues.

Finally, programs and policies that offer financial incentives to attract registered nurses to underserved areas—such as the National Health Service Corps and the Area Health Education Centers—may be critically important workforce strategies. When sufficiently funded, such programs could serve to offset the low mobility of new registered nurses that we observed. For example, the North Carolina Area Health Education Center nurse faculty members collaborate with nursing schools to offer off-campus "registered nurse to bachelor's degree in nursing" programs in underserved areas.[29] Nursing programs from more populated areas provide on-site courses in underserved areas rather than requiring students to travel to the program.

Our findings have additional implications in light of the Institute of Medicine's recommendation that 80 percent of registered nurses have a bachelor's degree by 2020.[30] Given registered nurses' low rate of geographic mobility and apparent preference for proximity to home, raising educational requirements while maintaining an adequate supply of registered nurses will be a formidable challenge in some markets. In many locales, associate's degree programs play a critical role in supplying new registered nurses.

Although about 50 percent of registered nurses in the United States have at least a bachelor's degree,[31] the percentage varies across geographic areas. Moreover, rural areas have a lower percentage of nurses with bachelor's degrees than other areas.[32,33] As states work to achieve the 80 percent goal, they should ensure that nurses with bachelor's degrees are not disproportionately located in suburban and urban areas. The development of partnerships, educational innovations, and new approaches for achieving these recommendations is crucial.

Data from our study show that new registered nurses are relatively immobile, both in an absolute sense and in comparison to other professional workers. The reasons for this immobility remain unclear. Understanding the reasons would provide additional options for policy makers to use to ensure an adequate supply of nurses across all areas of the country. ■

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23 A closer look at the registered nurses who did not report a high school location did not suggest any systematic differences between that group and the full sample. For example, 56.9 percent of those without a high school location earned an associate's degree as their first degree in nursing, and 34.7 percent earned a bachelor's degree. The largest share of registered nurses without a high school location were working in New York (19.5 percent), Texas (13.8 percent), New Jersey (13.8 percent), and North Carolina (10.8 percent). They were slightly older, on average, than the full sample (34.9 years), a bit more likely to be married (62.0 percent), and more likely to have children (55.7 percent, with 24.2 percent having children at home who were younger than six years old). Their distribution across metropolitan, micropolitan, and small town or rural areas was very close to that of the full sample. None of the differences was statistically significant.
24 Indeed, our analysis of census data found that New York ranked as the lowest state for geographic mobility. Close to 77 percent of native-born professional workers in New York had been born in the state. Texas ranked twenty-first out of fifty on this list (59 percent of native-born professionals there had been born in the state); New Jersey, twenty-ninth (53 percent); and North Carolina, thirtieth (52 percent).
25 Notably, registered nurses constitute a substantial share of people with a professional occupation and an associate's degree. Registered nurses were 21 percent of this group in the full population of adult workers and 26 percent in the subsample of early-career women. Registered nurses were less dominant among the population of bachelor's degree holders, although there, too, they were one of the largest occupational categories.
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Christine T. Kovner is a professor at the College of Nursing, New York University.

In this month's *Health Affairs*, Christine Kovner and coauthors report on their study on the geographic mobility of registered nurses (RNs). They found that 52.5 percent of RNs work within forty miles of where they attended high school, making nursing one of the least mobile professions for women. The authors make a series of recommendations for ensuring that underserved areas have an adequate RN workforce.

The paper grew out of a ten-year longitudinal study of the career trajectories of newly licensed registered nurses in the first ten years of their careers. Kovner is the principal investigator of that study, which is funded by the Robert Wood Johnson Foundation.

Kovner is a professor at the College of Nursing at New York University (NYU), a senior fellow at the Hartford Institute for Geriatric Nursing at NYU, an attending in nursing at the NYU Langone Medical Center, and a member of the executive committee of NYU's Clinical Translational Science Institute. She maintains an active research program involving studies on quality improvement, RNs' working conditions, and the cost of nursing care.

Kovner earned her master's degree in public health nursing from the University of Pennsylvania and her doctorate in nursing from NYU. She completed a three-year postdoctoral fellowship funded by the Agency for Healthcare Research and Quality.

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