

MEDICAID ADVISORY COMMITTEE

January 22nd

9:00a.m. – 12:00 p.m.

**General Services Building
Mazama Conference Room
1225 Ferry St. SE, Salem, Oregon**

Meeting Objectives:

- Learn about OHA’s Transformation Center and CCO Community Advisory Councils
- Develop an enhanced understanding of Oregon’s potential churn population
- Review and adopt guiding principles for churn work

Time	Item	Presenter
9:00	Opening Remarks	Co-Chairs
9:15	Approval of Minutes – December 2013	Committee
9:20	Oregon Health Authority - Standing update	Rhonda Busek, OHA
9:30	Oregon Health Authority Transformation Center - Learning Collaborates for CCOs in 2014 - Community Advisory Council survey and key findings	Chris DeMars, OHA; Maikia Moua, OHA
10:15	Oregon Health Study - OHP expansion population: health, cost and utilization profile - Oregon Churn Assessment	Bill Wright, Providence Center for Outcomes Research and Education
11:00	Break	
11:15	Enrollment Dynamics Between OHP and Exchange Coverage - Revised Guiding Principles - Assess differences in benefit coverage between OHP and Qualified Health Plans (QHPs)	Co-Chairs; staff
11:50	Public Comment or Testimony	
11:55	Closing comments	Co-Chairs; staff
11:55	Adjourn	

1. Agenda
2. Draft Minutes, December 2013
3. Transformation Overview
4. Oregon Newly Eligible OHP Members
5. Revised Guiding Principles
6. OHA/DHS Long Term Care CCO Study Group Report
7. Committee 2014 calendar
8. Oregon Health Study

The Oregon Health Authority's Transformation Center is the state's hub for health system innovation and improvement, and is key to encouraging the widespread adoption of the coordinated model of care. The center's goal is to increase the rate of innovation needed to deliver better health care at lower costs, and to improve the health of Oregonians.

Background

The center will support coordinated care organizations and an adoption of the model by organizing a system of peer-to-peer and rapid-cycle learning that includes an emphasis on:

- Learning systems such as collaboratives and rapid-cycle feedback of data and information
- Technical assistance
- Dissemination of best practices among CCOs, as well as other health plans and payers

The center's functions will include, but are not limited to:

Learning collaboratives. The center will support CCOs – and other plans and payers – learning from each other and from recognized experts. For the most part, the learning collaboratives will be open to all payers and will create opportunities for peer-to-peer learning and networking, the identification and sharing of evidence-based and emerging best-practices information, and the advancement of innovative strategies for promoting health.

Initial topic areas will likely include:

- New payment methods such as bundled payments, which incentivize improved efficiency, effectiveness and quality of health care;
- Physical and behavioral health care integration;

- Coordinating with community public health, community mental health, and long-term care supports and services;
- “Hot spotting” or “super-utilizer” initiatives;
- Provider and patient engagement;
- Health literacy;
- Reducing health disparities;
- Coordinated, community approaches to palliative and hospice care;
- Adoption of Patient-Centered Primary Care Standards.

Clinical standards and supports. The center will disseminate clinical standards and supports; for example:

- By working with the Health Evidence Review Commission to share evidence-based decision tools to assist providers and CCO Clinical Advisory Panels in delivering effective and efficient care.
- By working with specialty societies to maximize the impact and spread of the “Choosing Wisely” campaign.

Innovator Agents. In accordance with Oregon’s Medicaid waiver agreement with the Centers for Medicare and Medicaid Services, each CCO is assigned an Innovator Agent, who serves as a single point of contact between the CCO and OHA. Innovator Agents will provide data-driven feedback to CCOs on a monthly basis. In addition, they will assist CCOs’ providers and Community Advisory Councils in developing strategies to support quality improvement and the adoption of innovations in care, and gauge CCOs’ impact on health.

Council of Clinical Innovators. A Council of Clinical Innovators, along with the medical directors of the CCOs and other health plans, will serve as advisors and champions for the implementation of key innovations in the delivery and coordination of care. Members of the council will work with Oregon’s physician, specialty and other provider associations to spread the coordinated model of care.

Community and stakeholder engagement. In partnership with Innovator Agents and community partners, the center is developing strategies for effective community and stakeholder engagement around health system transformation and implementing the coordinated model of care.

Conferences/workshops, communications, outreach and networking. The center is developing methods for CCOs and other payers and stakeholders to learn and share information. This will include conferences and workshops; materials such as research, policy and practice guides; and communication and outreach to support the coordinated model of care.

Technical assistance and infrastructure support.

The center will connect CCOs, other payers adopting elements of the coordinated model of care and providers to expertise and technology resources that can offer assistance in effective delivery system reforms. Examples of supports include the use of health information technology, delivering quality data, and aligning financial incentives.

Regional Health Equity Coalitions (RHECs). The center will work with OHA’s Office of Equity and Inclusion to promote policies that support health equity and address social determinants of health. Through these coalitions, CCOs will have a bridge to communities that have been historically under-represented in health program and policy development; assistance in assuring representation of culturally and linguistically diverse communities on their governing board and Community Advisory Councils; and support to validate whether CCOs’ Community Health Improvement Plans are effectively addressing health disparities.

Data and analytics. OHA’s Office of Health Analytics, as a statewide aggregator of health care data and statistics, will support the center by providing timely and actionable data to improve targeting and delivery of services. The data will support accountability by measuring performance. It also will allow for clear communication to CCOs about performance, progress and opportunities for improvement.

The Transformation Center

Helping Good Ideas Travel Faster

Oregon Health Authority

Chris DeMars, MPH, Director of System Innovation

MaiKia Moua, RN, MPH, Transformation Analyst

The logo for the Oregon Health Authority. It features the word "Oregon" in a smaller, orange, serif font positioned above the "H" of the word "Health". The word "Health" is in a large, dark blue, serif font. Below "Health", the word "Authority" is written in a smaller, orange, serif font. A thin blue horizontal line is positioned just above the "Authority" text, extending from the left side of the "H" in "Health" to the right edge of the "Authority" text.

Oregon
Health
Authority

OHA's Transformation Center

- Supports health system innovation to achieve the triple aim:
 - Better health
 - Better care
 - Lower costs
- Transformation Center Goals:
 - Champion and promote transformation in partnership with coordinated care organizations, providers, and the communities they serve
 - Build an effective learning network for CCOs and CAC members
 - Foster the spread of the coordinated care model beyond Medicaid to other payers
 - Ensure state agency operations, policies and procedures support transformation

Transformation Center

Helps good ideas travel faster

- Supports health and health care innovation through learning collaboratives and other venues for sharing best practices and innovations in health care.

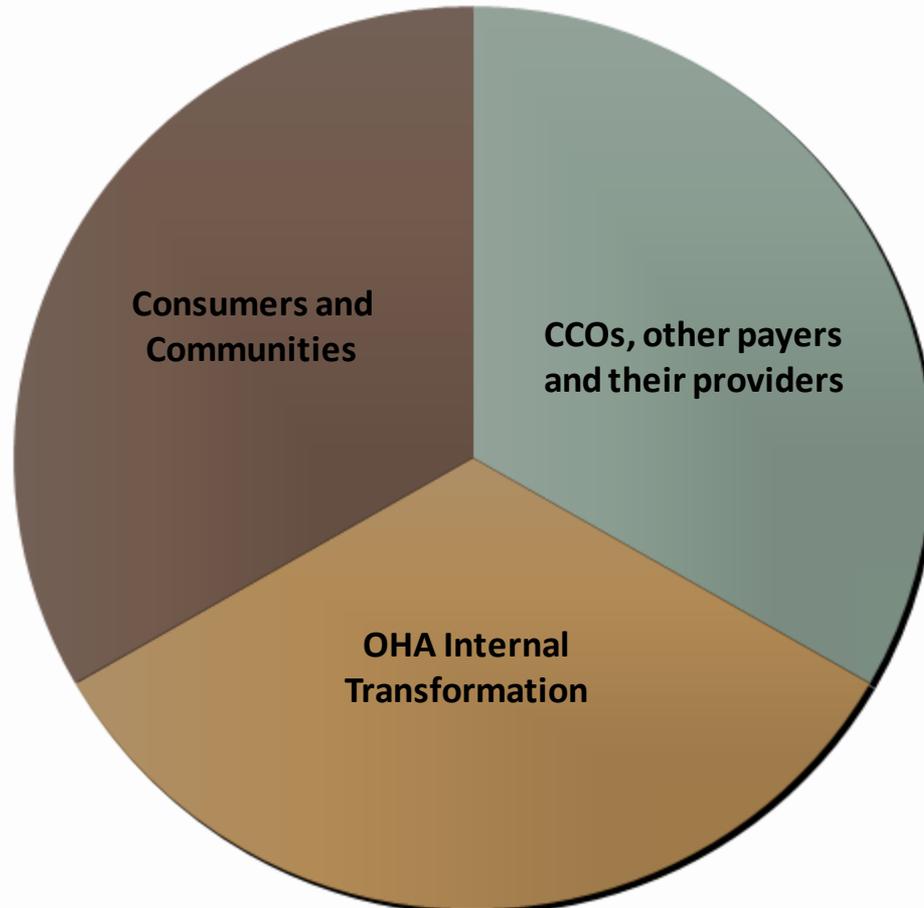
Supports health and health care innovation

- Promotes and shares best practices, innovative and emerging practices, and activities that lead to better health for Oregonians.
- Connects with partners and stakeholders across all sectors.

Provides supports and streamlining

- Provides the supports and streamlining necessary to foster innovation within the health system.
- Helps shift OHA from a regulatory oriented agency to one that is customer-service oriented.

Who the Transformation Center Serves



What Does the Transformation Center Do?

- **Transformation Center offers:**

- Learning collaboratives, peer-to-peer networks
- Technical assistance and infrastructure support
- Conferences (e.g., CCO Summit) and workshops, communications, outreach and networking
- Innovator Agents
- “Transformation Ideas” Bank to support transformation spread
- Connections with Data & Analytics
- Health equity promotion strategies in partnership with Office of Equity & Inclusion
- Council of Clinical Innovators will be offered, including clinical standards & supports

Current Transformation Center Learning Networks

- Statewide Community Advisory Council Learning Community
 - Monthly meetings allow CAC members to learn about other CACs and best practices from outside experts
 - Future plans: statewide CAC Summit & a CAC leadership program
- Statewide CCO Learning Collaborative
 - Monthly gathering of CCO Medical Directors & Quality Improvement Coordinators focusing on the 17 CCO incentive metrics
- Complex Care Collaborative
 - CCO staff & providers share ideas and learn about innovative care models to address needs of complex patients

Transformation Center's Support of Clinical Innovation

- The Transformation Center is creating a Council of Clinical Innovators:
 - a cohort of provider fellows who will serve as champions for the implementation of key innovations in the delivery and coordination of care.
- The Center disseminates clinical standards and supports.

Innovator Agents

- Innovator Agents, which are required for CCOs according to statute and waiver, play the following roles:
 - Serve as a single point of contact for the CCOs with the OHA to improve communications and identify solutions.
 - Support CCO's innovation strategies in line with its Transformation Plan.
 - Supports the CCO's connections with the broader community
 - Engaged with and support CCOs' Community Advisory Councils.

CCO Transformation Fund grants

- Transformation Center recently managed award of CCOs' Transformation Fund Grants.
- Example focus areas:
 - Health information exchange and electronic medical records
 - Integration of care, clinical integration
 - Member engagement
 - Health system integration
 - Community: education, information sharing, prevention programs, CAC support
 - Workforce development: hiring, provider training
 - Patient-Centered Primary Care Home development
 - Practice evaluation, data collection, health analytics
 - Alternative payment methods

Community Advisory Councils (CACs)

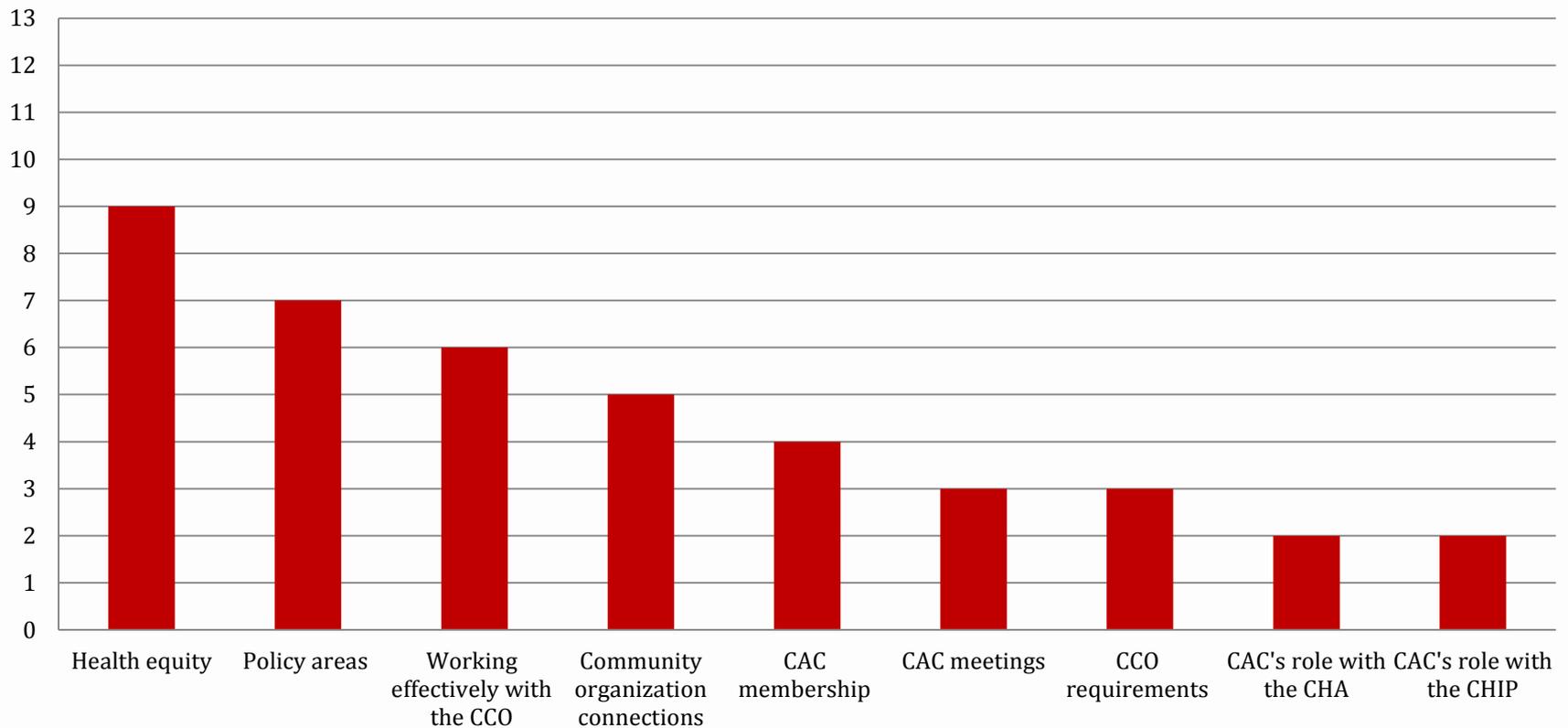
- CCOs shall establish CAC(s), which:
 - Identify and advocate for preventive care practices to be utilized by the CCO
 - Oversee a community health assessment (CHA) and adopt a community health improvement plan (CHIP) to serve as strategic guidance for the CCO to address health disparities and meet health needs for the communities in their service area(s)
 - Annually publish a report on the progress of the CHIP

Total number of CACs around the state = 37

- AllCare Health Plan: 3
- Cascade Health Alliance: 1
- Columbia Pacific CCO: 5
- Eastern Oregon CCO: 13
- FamilyCare, Inc: 1
- HealthShare of Oregon: 1
- Intercommunity Health Network: 3
- Jackson Care Connect: 1
- PacificSource Central Oregon: 1
- PacificSource Columbia Gorge: 1
- PrimaryHealth of Josephine Co: 1
- Trillium Community Health Plan: 2
- Umpqua Health Alliance: 1
- Western Oregon Advanced Health: 1
- Willamette Valley Community Health: 1
- Yamhill County Care Organization: 1

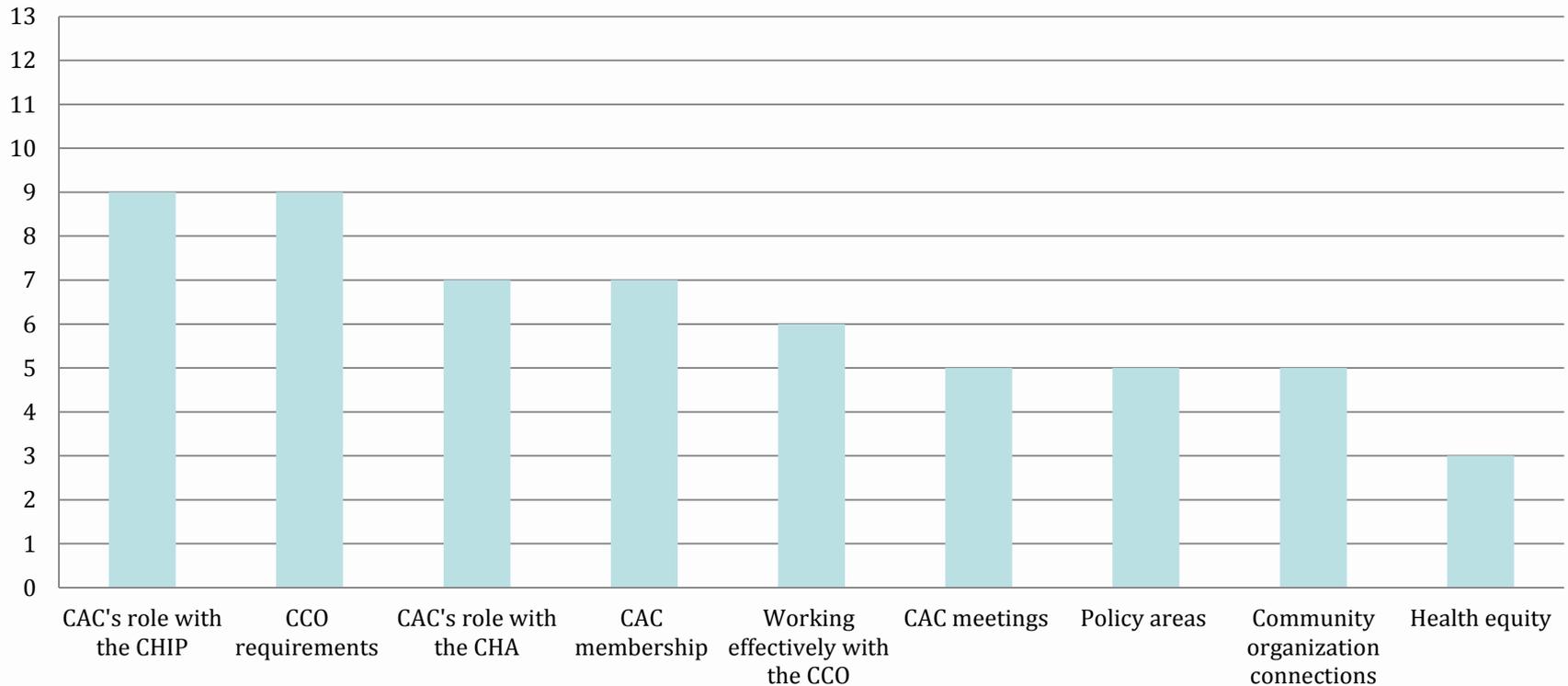
Transformation Center CAC Survey #1 (June-July 2013)

Table 5: Topics for statewide CAC convening (Q1)



Transformation Center CAC Survey #1 (June-July 2013)

Topics for CAC-specific technical assistance



Transformation Center CAC Survey #2 (November 2013): Meeting Preferences

Highlights :

- The most valuable attribute to the CAC learning community meetings has been the ability to share and hear about projects occurring around the state, learning how CCOs operate and networking with other CAC members
- The greatest interest for learning community meetings is to have more information and learning about CHAs and CHIPs
- The greatest need CAC members have for an in-person CAC gathering are networking opportunities, hearing success stories, and help establishing clear objectives and guidance in creating measurable outcomes for their role.

Summary of CAC Topics of Interest/Need

- Health disparities and promoting health equity
- Policy areas (behavioral health, prevention, social determinants of health, trauma, understanding data, health care financing)
- Working effectively with the CCO
- Clarity on CACs role with CHA and CHIPs
- Understanding CCO requirements (Transformation Plan elements, metrics, incentive payments, performance improvement projects)

Summary of CAC Topics of Interest/Need (Cont.)

- Recruiting, selecting, and retaining CAC members
- Sharing and hearing about projects happening around the state, learning how CCOs operate and more networking
- More information and learning about CHAs and CHIPs
- Continued networking, hearing success stories, and help to establish clear objectives, and guidance in creating measurable outcomes

CAC Technical Assistance

Technical Assistance is available through the Transformation Center.

Examples of TA :

- Lake County, CHIP support from OHA-Public Health Division
- Intercommunity Health Alliance, contracted support for CAC strategic planning (goal setting, effective communication, council development)

Transformation Center Supports for CACs in 2014

- Convene CAC Steering Committee in Jan. 2104
- Continue monthly CAC learning community meetings
- CAC Summit (Summer 2014)
- CAC Leadership Institute (Fall 2014)
- Continue availability of technical assistance
- Additional communications support via Groupsite discussions

Questions?

More information at:

TransformationCenter.org

Transformation Center events:

Transformationcenter.org/events/

Health System Transformation

Health.Oregon.gov

Oregon Statewide

Health & care profile

for newly eligible Oregonians under the ACA

OVERVIEW

CONTENTS: This document profiles health and utilization measures of uninsured people up to 138% of Federal Poverty Level as of 2012 across the different CCO service areas in Oregon.

SOURCE OF DATA: This profile was produced using survey data from the Oregon Health Insurance Experiment (OHIE). As the first ever randomized controlled trial on the impacts of health insurance, the OHIE has been longitudinally following tens of thousands of low-income Oregonians who signed up for the Oregon Health Plan “lottery.” Because most of these individuals are still uninsured and have already sought Medicaid coverage, they represent a population of likely “early adopters” once Medicaid expansion goes into effect in 2014.

The profile for Oregon is based on **38,222 UNIQUE INDIVIDUALS** from the OHIE’s 2010-2012 data collection period. All participants were uninsured as of their most recent survey, projected to fall within Medicaid age limits at the start of 2014.

PROFILE TYPES: We relied on each individual’s most recent survey response for variables that were time-sensitive. Using this data, we provide three types of information:

1. HEALTH PROFILES, including chronic condition prevalence, and
2. UTILIZATION PROFILES, capturing current levels of utilization while uninsured.
3. DEMOGRAPHIC PROFILES, including race, education, income, and family composition.

1. HEALTH PROFILE

CHRONIC CONDITIONS: Analysis of survey data provides estimates of chronic condition prevalence among the Medicaid-eligible population. These data are best seen as conservative estimates because they rely on having received a diagnosis, which implies at least some access to care. Results suggest that depression/anxiety and high blood pressure are fairly common chronic health conditions among this population. Only a third has never been diagnosed with any of the listed conditions. It is also fairly common for individuals with a given condition to not be taking prescribed medications for it.

CHRONIC CONDITION DIAGNOSES

CHRONIC HEALTH CONDITIONS <i>Have you ever been told by a health professional that you have...</i>	PERCENT TOLD THEY HAVE IT BY A PHYSICIAN (n = 38,222)	OF THOSE, PERCENT CURRENTLY TAKING MEDICATION FOR IT
Diabetes	11.3	67.8
High cholesterol	22.0	45.9
High blood pressure	29.7	59.9
Depression/anxiety	44.2	51.4
Asthma	18.7	56.0
Emphysema/COPD	7.2	49.0
Heart attack/Angina	5.9	54.6
Congestive heart failure	1.9	57.8
Kidney problem	6.4	30.1
Cancer	4.7	22.3
Never diagnosed with any of the above	31.2	n/a

OTHER HEALTH INFORMATION: The surveys also collected some other general health information, including self-assessments of overall health and health trajectory, impairment and ability to work, a short clinical screen for current depression (Patient Health Questionnaire-2; PHQ-2), as well as smoking status. Results are summarized below.

GENERAL HEALTH PROFILE

OTHER HEALTH MEASURES	Percent
Overall Health: Poor or Fair	42.4
Health Trajectory: Health getting worse over the last 6 months	31.8
Percent Whose Health Currently Limits Ability to Work	38.0
Percent Who Screened Positive for Current Depression (PHQ-2)	32.1
Currently Smoke	40.1

2. UTILIZATION PROFILE

ACCESS TO CARE: Access to care has been poor among this population. Using the most recent year’s data for each individual, we estimate that more than four in ten will lack connection to a usual care source, and the majority of those who have recently needed health care say they have been unable to get all the care they need.

RECENT ACCESS TO CARE

ACCESS TO CARE MEASURE	Percent
Percent Who Have A Usual Place Of Care	60.0
Percent Who Have A Personal Doctor	45.1
Of Those Who Needed Care, Percent That Didn’t Get It (last 6 months)	
--Medical Care	64.0
--Mental Health Care	78.0
--Prescription Medications	50.0
--Dental Care	86.4

USE OF OUTPATIENT AND PREVENTIVE CARE: Utilization of outpatient care and preventive screenings are shown below. Rates of screenings for common chronic conditions such as diabetes and cholesterol were moderate to low.

OUTPATIENT UTILIZATION & PREVENTIVE SCREENINGS

OUTPATIENT UTILIZATION	Percent	PREVENTIVE SCREENINGS	Percent
Outpatient Visits in past six months		Have Never Had...	
--None	43.4	--HIV Screening	52.3
--One to two	32.4	--Hepatitis C Screen	55.5
--Three to four	15.4	--Mammogram (female 40+)	28.4
--Five to seven	5.3	--Pap test (female)	5.1
--Eight or more	3.5	--Rectal exam (male 50+)	40.5
		--Diabetes Screening	42.3
Average # of Outpatient Visits (6 Months)	1.81	--Cholesterol Screening	39.0

USE OF ED & ACUTE CARE: Emergency Department visits and inpatient utilization are summarized below. About slightly more than one in three have used the ED at least once in the past six months, and nearly one in ten had been a hospital inpatient at least overnight.

RATES OF ED USE & INPATIENT STAYS

ED UTILIZATION	Percent	INPATIENT UTILIZATION*	Percent
ED Visits in the Past 6 Months		Hospital Stays in the Past 6 Months	
--None	73.1	--None	91.9
--One	15.4	--One	5.8
--Two	6.5	--Two	1.3
--Three or More	4.9	--Three or More	1.0

*Excludes childbirth

3. DEMOGRAPHIC PROFILE

We have included individuals with incomes above 138% FPL in this final table because their incomes vary, and they may be income eligible for Medicaid in 2014 even if they would not have been at the time of their most recent survey. Results are summarized below.

DEMOGRAPHIC PROFILE

MEASURE	PERCENT
GENDER	
Female	58.0
AGE	
19-34	26.7
35-49	32.9
50-64	40.4
RACE/ETHNICITY	
Hispanic	10.0
White (Non-Hispanic)	75.3
Black or African American	2.7
Other (including multiracial or unknown)	12.0
EDUCATION	
High school diploma or less	65.2

MEASURE	PERCENT
EMPLOYMENT	
Employed	32.3
Self-employed	9.1
Unemployed	54.1
Retired	4.5
APPROX HOUSEHOLD INCOME (% of FPL)*	
100% and below	59.9
101%-138%	15.0
139% and above	25.0
NUMBER OF DEPENDENTS	
0	60.4
1-2	29.8
3+	9.8

*Federal Poverty Level (FPL) based on Federal poverty calculation guidelines, found at <http://aspe.hhs.gov/poverty/index.cfm>

CONTACT

Please contact Bill J. Wright, PhD, Senior Research Scientist, 503.215.7184, Center for Outcomes Research & Education, Providence Health & Services, with questions about this document.

Medicaid Advisory Committee

Decision-making Criteria for Oregon’s Churn Mitigation Options

When fully implemented by January 1, 2014, the federal Affordable Care Act (ACA) will increase the number of insured Oregonians through two primary strategies – expanding Medicaid and providing insurance through a state-based insurance exchange. As an individual’s household income exceeds the maximum for Medicaid eligibility, he or she will be eligible for subsidies to buy coverage through an exchange, up to a household income of 400 percent of the federal poverty level (FPL). This switch in eligibility also works in reverse. If an individual's household income falls at or below 138% FPL, he or she will become eligible for Medicaid. A key design challenge for those tasked with implementing the reform law is how to manage this "churning" phenomenon – when individuals cycle in and out of public programs as their incomes fluctuate – so that disruptions in care and other adverse impacts are minimized. To address this issue, Oregon’s Medicaid Advisory Committee (MAC) will carefully examine the issue of churn and put forth a set of proposed policy options intended to mitigate its effects among Oregonians. The Committee will make recommendations to the Oregon Health Policy Board that seek to mitigate the impacts for individuals and families that transition between the Oregon Health Plan (OHP) and qualified health plans (QHPs) in the Exchange.

The Medicaid Advisory Committee is charged with advising the Oregon Health Authority (OHA) and the Oregon Health Policy Board on the operation of Oregon’s Medicaid program, the Oregon Health Plan (OHP) (ORS 414.221). The committee is composed of consumers, providers serving OHP members, representatives of health care organizations and Coordinated Care Organizations (CCOs), and advocates familiar with the needs among individuals and families served by OHP. Consequently the MAC assumes a special responsibility to speak on behalf of the Medicaid population and how they experience the health care system. As the MAC considers options to mitigate the effects of churn between Medicaid and commercial coverage, the committee elected to adopt a set of decision-making criteria or “principles” to guide their work.

Principles for Evaluation of Churn Mitigation Strategies

- **Maximize affordability, benefit coverage, and continuity of care for individuals and families**
 - **Consider the health care needs of diverse subpopulations, parents, women, children, persons with disabilities, and residents in rural and frontier areas, among others served by OHP**
 - **Balance consumer needs with the state Medicaid program and the health insurance exchange operational feasibility and financial self-sustainability**
 - **Promote coverage options that ensure access and continuity to comprehensive health services and result in the lowest net level of churn**
-

Report to the Centers for Medicare & Medicaid Services

STUDY GROUP REPORT ON THE INTEGRATION OF LONG TERM CARE SERVICES INTO THE GLOBAL BUDGETS OF OREGON'S COORDINATED CARE ORGANIZATIONS

DECEMBER 20, 2013

Submitted by the Oregon
Department of Human
Services and the Oregon
Health Authority Long Term
Care/Coordinated Care
Organizations (LTC/CCO)
Study Group



Table of Contents

Acknowledgements	3
Executive Summary.....	5
Introduction.....	8
Potential Opportunities and Barriers to Integration.....	12
Background Research into Integration Models.....	17
Strategies and Outcomes: Working through Straw Models	24
The Oregon Model Framework for Integration and Coordination.....	25
Timeline	31
Shared Accountability	35
Conclusion.....	37
Appendix I: Study Group Roster	38
Appendix II: Aspiration Rankings of Oregon Straw Model.....	40
Appendix III: Oregon’s Coordinated & Integrated LTSS & CCO Framework	41
Appendix IV: Shared Accountability Sub-Committee Report.....	49
Appendix V: Performance Measures Selection Criteria for Shared Accountability Metrics.....	54
Appendix VI. Public Comments	55

Acknowledgements

This Oregon Health Authority (OHA) and Oregon Department of Human Services (DHS) report to the Centers for Medicare & Medicaid Services (CMS) was jointly developed with support from the Center for Health Care Strategies, Inc. (CHCS) and contributions from the Long Term Care/Coordinated Care Organizations (LTC/CCO) Study Group members.

Study Group Members and Contributors: Ruth Bauman, Liz Baxter, Donald Bruland, Carol Burgdorf-Lackes, Jim Carlson, Jerry Cohen, Terry Coplin, Stephanie Dockweiler, Chris Flammang, Ellen Garcia, Mary Guillen, Ruth Gulyas, Tim Malone, Ruth McEwen, Wayne Miya, Meghan Moyer, Margaret Rowland, Rodney Schroeder, Tina Treasure, and Michael Volpe.

Staff Contributors:

Oregon Health Authority: Jeffrey Scroggin (OHA Lead)

Oregon Department of Human Services: Bob Weir (DHS Lead)

Max Brown, Selina Hickman, Chelas Kronenberg, Naomi Sacks

Daniel Amos, Jeannette Hulse, Ann McQueen, Chris Sanchez

Center for Health Care Strategies: Alice Lind (Facilitator) and Brianna Ensslin

CHCS was pleased to be asked by DHS and OHA to serve as a neutral convener and facilitator for Oregon's Study Group stakeholder engagement process. CHCS, a nonprofit health policy resource center, has long helped states across the country in reengineering Medicaid long term services and supports (LTSS) programs to provide more person-centered home- and community-based services, thereby allowing individuals to remain living in their communities.

Oregon has participated in several CHCS initiatives focused on LTSS and improving care for individuals enrolled in both Medicare and Medicaid and was highlighted in a 2010 CHCS report focusing on state LTSS best practices.¹

¹ A. Lind, S. Gore, and S. Somers. *Profiles of State Innovation: Roadmap for Rebalancing Long Term Supports and Services*. Center for Health Care Strategies, November 2010.

CHCS commends Oregon's commitment to innovation, stakeholder involvement, and its data-driven approach to program design. It was a pleasure to support the state as it considers how to best coordinate LTSS with the medical and behavioral health care provided by the CCOs. The members of the Study Group showed tremendous dedication and contributed a broad range of expertise and thoughtful deliberation to their discussions. CHCS hopes that this report conveys the enthusiasm and diversity of opinion that the Study Group members brought to the task.

Executive Summary

As part of the Special Terms and Conditions of the Section 1115 Demonstration implementing the Oregon Health Authority's (OHA's) work on Health System Transformation, Oregon agreed to conduct an exploratory stakeholder process regarding the integration of the Department of Human Services' (DHS') long term care (LTC) services into the global budgets of Coordinated Care Organizations (CCOs). This report to the Centers for Medicare & Medicaid Services (CMS) serves to meet the requirements of the agreement by describing the opportunities, barriers, and strategies for integration of long term care, along with issues of scope, process, and timeline. The framework depicted in this report represents the work of Oregon's 2013 Study Group, and it is intended to foster greater coordination and integration between the CCO and long term services and supports (LTSS) systems while supporting Oregon Revised Statutes (ORS) Chapter 410's values and Oregon's Triple Aim.²

The Study Group explored opportunities and barriers to integration and coordination. In preparation for its discussions of an Oregon model, the Study Group also examined several Oregon pilots and initiatives for care coordination, national and state level data, and different systems of care coordination in other states. Many of these models prioritize the needs of high-risk beneficiaries, and the Study Group returned to that theme frequently during its deliberations. In its final three meetings, the Study Group developed a model framework for integration and coordination using the following domains:

- Care team/Care plan and coordination across providers;
- Financing/Contracting;
- Performance, quality measurement, and monitoring;

² ORS 410 establishes the principle of LTSS – and services more broadly for seniors and people with disabilities – to maximize one's independence, choice and dignity: "The Legislative Assembly finds and declares that, in keeping with the traditional concept of the inherent dignity of the individual in our democratic society, the older citizens of this state are entitled to enjoy their later years in health, honor and dignity, and citizens with disabilities are entitled to live lives of maximum freedom and independence" (ORS 410.010). The Triple Aim refers to Oregon's Health System Transformation's goals of better health, better health care, at lower costs.

- Data and information sharing;
- Public and stakeholder engagement;
- Consumer engagement; and
- Medicare.

The Study Group identified recommendations to better integrate and coordinate LTSS and health systems and provide a road map for the future. The Study Group's framework is based on Oregon's Triple Aim and ORS 410 Values and includes:

- Developing shared accountability and shared savings through flexible and outcome focused metrics, incentives and penalties, financial mechanisms to address inappropriate cost shifting, risk adjustments, alternative payment methodologies and other appropriate financial mechanisms. Yearly milestones, metrics development, base-lining, and financial mechanisms will be phased in over a four year period with full implementation before 2018;
- Emphasizing the importance and need for better coordination across systems using a team based approach, as well as duplication and inefficiency reduction through clearly defined interdisciplinary team roles and responsibilities;
- Using local flexibility, risk bearing responsibility, capacity, links to Patient-Centered Primary Care Homes, and knowledge of an individual's needs as criteria to select an entity responsible for care coordination across providers.
- Supporting and encouraging local control through data-driven innovation, contract flexibility and innovative pilots; barriers to contracting are identified and removed as appropriate.

While the Study Group spent significant energy and time examining integration of LTSS into CCO global budgets, the integrated and coordinated framework developed by the Study Group for Oregon does not recommend that LTSS be included into CCO global budgets. However, a minority opinion held that in the

future, such financial integration may be possible and in fact desirable, but only with strong protections for continued consumer choice, greatest independence, preservation of the dignity of individuals and a non-medical model.

OHA and DHS support the Study Group's recommendations and will build a project plan before 1 March 2014 to operationalize these concepts. Implementation of these recommendations should improve the outcomes and quality of life of those receiving Long Term Services and Supports.

Introduction

In December 2012, Oregon reached agreement with the Centers for Medicare & Medicaid Services (CMS) on the Special Terms and Conditions of the Section 1115 Demonstration implementing the Oregon Health Authority's (OHA's) work on Health System Transformation. Two requirements included in this agreement were: 1) an Accountability Plan and Expenditure Trend Review; and 2) a report on the integration of the Department of Human Services' (DHS) Long Term Care (LTC) services in the global budgets of the newly-created Coordinated Care Organizations (CCOs):

Oregon has agreed to conduct an exploratory stakeholder process that would result in a report to CMS regarding the integration of DHS Medicaid-funded long term care for seniors or people with disabilities into CCO global budgets. The report will identify opportunities, barriers, and strategies for integrating long term care, and address issues of scope, process and timeline for integration. The report will be submitted to CMS no later than December 31, 2013.³

This report is submitted to CMS in fulfillment of the latter requirement.

DHS Director, Erinn Kelley-Siel, announced this requirement to the department's Aging and People with Disabilities (APD) stakeholder community on December 21, 2012 and informed them that DHS and OHA would take steps to meet the requirement. The stakeholder process would be inclusive and would not have a pre-determined outcome or result. The approach would also be transparent, data-driven and focused on the needs of consumers.

On January 30, 2013, Kelley-Siel and OHA Director, Bruce Goldberg, MD, called for nominations of APD and OHA stakeholders to serve on the stakeholder group that would develop recommendations for this report. In March, a group of 20 stakeholders – known as the LTC/CCO Study Group (Study Group) – was selected to develop suggestions for an Oregon approach to integrating long term services

³ Centers for Medicare and Medicaid Services Amended Waiver List and Expenditure Authority, Numbers 21-W-00013/10 and 11-W-00160/10, p. 328.

and supports (LTSS)⁴ into the CCO model of care delivery. These 20 members were selected from approximately 120 applicants to represent a broad range of perspectives and included five representatives each of LTSS consumers, CCO consumers, LTSS providers, and CCO providers.⁵ Given the requirements of the Accountability Plan, the Study Group's charge included the following:

- Explore the integration of DHS' Medicaid-funded LTC for seniors and people with disabilities into the CCO global budget;⁶
- Identify strategies to improve outcomes and quality of services delivered to consumers of LTSS and consumers of the health system through better coordination, integration, and communication;
- Address issues of scope, process, timeline, and feasibility for the integration of LTSS into the CCO global budget; and
- Contribute to a report to CMS addressing the above.

The Study Group met six times from May through October 2013. An additional optional meeting was held by phone in November to discuss the draft timeline. After an introductory meeting, the group first identified Oregon's opportunities and barriers to integrating LTSS into CCO global budgets. Next, the Study Group explored other state models of integration and discussed what the Oregon definition of integration should look like. The Study Group then turned to general and Oregon-specific straw models for integration, each of which included a continuum ranging from no integration to full integration. Finally, the group sought agreement on what integration in Oregon would look like, including strategies and outcomes of integration that could overcome the barriers and seize the opportunities of LTSS-CCO coordination that the Study Group had previously identified. At nearly every meeting, there was a personal story from the consumer

⁴ In this report and in the Study Group deliberations, "LTSS" represents the set of services that are delivered through Oregon's waivers and State Plan, including institutional and HCBS. "LTC" was the term used in the federal application for funds that support the work, so the group's formal name uses the LTC acronym. In the charge to the group, "LTC" refers to Medicaid-funded services that support individuals in both institutional and community settings.

⁵ A roster of the Study Group is provided in Appendix I.

⁶ CCOs, created under federal authority in 2012, are given a global budget to manage a wide range of health and human services, including medical and mental health care. In Oregon, LTSS were specifically carved out of the global budgets by state legislation.

perspective regarding consumer experiences with the coordination of health care and LTSS. Public comment was taken at each of the meetings as well. Staff to the Study Group maintained a website so that the public could view all meeting materials, and a toll-free conference call line was available to any Study Group member or member of the public who could not attend meetings in person. The proposed final draft of this report was posted on the web for a two-week public comment period.

In conjunction with this work, the Study Group formed a Shared Accountability Sub-Committee, which met five times from June through October 2013. The Sub-Committee's charge was three-fold:

- To identify opportunities, strategies, and barriers for monitoring and evaluation strategies for the model(s) proposed by the Study Group;
- To recommend LTSS/CCO draft metrics and strategies for shared fiscal savings and incentive/penalty models for shared accountability between LTSS and CCO services; and
- To undertake other tasks or work as decided by the Sub-Committee.⁷

As the Study Group began, the members needed to factor two larger themes into their discussions. First, a growing number of states have either adopted or are in the process of integrating at least some LTSS into Medicaid managed care plans as a means of reducing fragmentation of care, improving care coordination, and rebalancing the provision of LTSS towards home- and community-based services (HCBS). As of 2012, 440,000 LTSS consumers were enrolled in managed long term services and supports (MLTSS) programs nationwide, with 17 states having some form of a MLTSS program operational and several more in the process of starting such a program.⁸ Particularly in states seeking to reduce institutional care as

⁷ These other tasks were associated with Oregon's ongoing work on shared accountability between the medical and LTSS systems. In addition to creating a set of metrics, the strategies of shared accountability include Memoranda of Understanding (MOUs) between CCOs and LTSS local offices, requirements (through rules and contracts) to coordinate between the two systems, and eventually, strategies of shared financial accountability between CCOs and LTSS.

⁸ It is projected that 26 states will have an MLTSS program by 2014. See *The Growth of Managed Long Term Services and Supports Programs: A 2012 Update*, Truven Health Analytics for Centers for Medicare & Medicaid Services, July 2012.

Oregon has done and to rebalance spending on LTSS from skilled nursing facility care to HCBS, there has been a trend toward capitated models, especially for targeted populations (e.g., the financial alignment demonstration projects that integrate services for dual eligibles). The 2011 legislation that created Oregon's CCOs (House Bill 3650) kept the budget and the administration of the Medicaid LTSS system under DHS's Aging and People with Disabilities program, while CCO global budgets cover Medicaid-funded physical health, mental and behavioral health, and oral health care.

Second, Oregon has achieved the following:

- In OHA's global budget system, sustainable fixed rates of growth and locally coordinated care; low hospitalization rates; and cost savings of \$15 billion per federal evaluations of Oregon's 1115 waiver/Medicaid budget neutrality since 1989;
- In the LTSS system, low reliance on institutional care and a well-developed community-based model;
- Among the highest rates of individuals in managed medical care, both in Medicaid (78 percent overall, 61 percent of individuals who are dually eligible for Medicaid and Medicare) and Medicare (40 percent overall, 47 percent of individuals who are dually eligible).⁹

Given the national trends and the separate administration and financing of LTSS, along with a mature medical managed care system in Oregon, the Study Group was encouraged to explore the opportunities and barriers with the understanding that they could define "integration" for Oregon without feeling constrained by existing models of integration in other states or programs.

⁹ Oregon Health Authority, "Proposal to the Centers for Medicare and Medicaid Services: Medicare/Medicaid Alignment Demonstration to Integrate Care for Individuals who are Dually Eligible," 11 May 2012, p. 6.

Potential Opportunities and Barriers to Integration

The Study Group first had to consider opportunities and barriers to care and services in the current model as it explored the integration of LTSS into CCO global budgets. The group recognized that not all solutions require financial integration. Prior to their second meeting, the Study Group members responded to a survey that helped to identify some of these opportunities and barriers.¹⁰ Their responses were used to help initiate open conversations that expanded and refined the list of opportunities and barriers originally created by the Study Group. Opportunities and barriers were grouped into the following categories:

- Consumer outcomes and empowerment;
- Capacity and access;
- Coordination and communication;
- Prevention; and
- Financing and shared savings.

Consumer Outcomes and Empowerment

The Study Group thought that the best way to identify barriers to consumer outcomes and empowerment was to understand why some consumers are not getting the right care and the right services at the right time. One reason is that some consumers may not know what supports are available to them. If LTSS were integrated into CCOs, the Study Group felt strongly that the principles of the social model, with its commitment to consumer empowerment, should carry over into a new service delivery system.

¹⁰ Barriers included: lack of CCO experience with LTSS; potential reduction in quality of care; concerns regarding funding; difficulty changing the status quo; difficulty of program oversight; and concerns over workload. Opportunities included: more coordinated and comprehensive care without cost-shifting; consumer input would be more valued; care would be more innovative, patient/consumer-centered, and prevention-oriented; inappropriate service use would be reduced, and better prescription drug reviews for home- and community-based settings.

The Study Group found many possible opportunities that would come with integration. Integration may lead to the ability to offer flexible LTSS (and health) services in partnership with the CCO delivery model. If so, there would be an opportunity to offer LTSS not currently reimbursed by Medicaid, such as socialization services to help counter the isolation many LTSS consumers currently experience, which could also be offered via a collaborative approach. Integration may also provide the resources for more robust consumer satisfaction data collection and measures. This would enable the provision of more individual-centered services and supports that focus on the whole person – in terms of the consumer’s health, independence, and quality of life.

Capacity and Access

The Study Group identified both opportunities and barriers related to the topic of capacity and access to health and LTSS services. One barrier is the lack of CCO experience in providing LTSS services and in handling consumer transitions from acute and rehabilitative settings to their homes and communities. The lack of inclusion of Medicare-covered benefits in financial integration is also a barrier as unnecessary emergency room use, inappropriate hospitalizations, and prescription drug costs are major cost drivers of services for people dually eligible.

Capacity barriers also include a lack of off-hours access to urgent care, a lack of access to mental health services for older adults, a lack of expertise in providing mental health services to older adults, general provider network concerns in some areas of the state, and low capacity of trained providers and case managers in some areas of the state.

The opportunities for capacity and access include the potential to deliver medical services in LTSS settings and the flexibility to offer continuity of the personal care provider during acute stays in medical service settings. Study Group members discussed the fact that the current medical system is organized according to a physician’s office model of service delivery in which patients must travel to receive services at a physician’s office. This model, however, does not fit with the

needs of many seniors and people with disabilities who do not have access to adequate transportation. Particular challenges are faced by consumers living in Oregon's largely rural landscape, and the Study Group expressed concern about the ability of both systems to meet consumers' needs in different parts of the state. CCOs, through flexible services, may have the ability to bring medical services to the LTSS consumer's place of residence.

Coordination and Communication

Coordination and communication between medical and LTSS providers were two main focuses of opportunities and barriers presented by the integration of LTSS services into CCOs. The Study Group looked at the Program of All-Inclusive Care for the Elderly (PACE) model, which integrates medical and LTSS services for individuals age 55 and older. One barrier to integration is the use of different terminology between the two systems (much of which is attributed to the differences between the medical and social models of care and service delivery). Another barrier beyond language and terminology is the infrastructure of communication itself: the LTSS and medical systems have different information systems, and the interoperability barriers would require a substantial investment in resources to surmount. Financial barriers to coordination also exist because the two systems have different payers funding different benefits that consumers receive from LTSS and medical services. Moreover, when coordination of medical and LTSS services have been attempted through pilot programs, providers in each system found it difficult to sustain coordination over time.

Given the barriers listed above, integration holds potential for coordination by breaking down the silos between the health and LTSS delivery systems, creating a common language between the two provider networks, and finding short-term and long term strategies for communication and information sharing between the two systems. In particular, the Study Group found that Oregon's approach to coordination or integration created the groundwork for better transitions to home and community-based settings in which care and services are seamlessly delivered to address both the medical needs and the social needs and goals of consumers.

Prevention

The barriers to integration related to prevention include a population not served by CCOs: seniors and people with disabilities who are at risk of Medicaid eligibility. For those eligible for Medicaid, prevention barriers include the ongoing problem of inappropriate hospital use.

The Study Group found opportunities for integration through better coordination to prevent inappropriate hospitalization or use of other higher cost interventions. In particular, stronger community mental health services for seniors and people with disabilities would prevent inpatient psychiatric stays. Integration also presents the opportunity to consider flexible preventative services for populations at risk of Medicaid eligibility or to expand LTSS eligibility to those already receiving Medicare and medically-related Medicaid services, but not yet receiving LTSS.

Financing and Shared Savings

One of the biggest barriers to integrating LTSS and CCO services lies in the area of financing and shared savings. For example, Oregon's LTSS program has been a national leader in financial savings because 84 percent of the LTSS population receives HCBS rather than institutional care. The Study Group wondered if the current efforts at shared accountability are not generating enough savings and whether further integration had any capacity to generate more savings. Other barriers include the effort that would need to be undertaken by CCOs to build a new LTSS provider network, the uncertainty of provider payments under a CCO global budget, and statutory barriers to financial integration.

Given these barriers, the Study Group found some possible opportunities with integration for financing services. Opportunities include using shared savings gleaned from inappropriate hospitalizations and better coordination to fund flexible services and mental health services. Integration, if coupled with a Medicare-Medicaid demonstration, may also create the opportunity to change the three-day hospitalization rule for fee-for-service Medicare recipients and

enable them to gain access to Medicare coverage for services at skilled nursing facilities.

While not all identified opportunities were adopted in the final recommendations, these ideas provided a wide variety of alternatives for the Study Group to accept or reject as a compatible and feasible vision of integration for Oregon.

Background Research into Integration Models

Given the aforementioned opportunities and barriers related to integration, the Study Group engaged in a process that examined Oregon’s initiatives, programs, pilot programs and proposals, national and state data, and other state integration models through MLTSS.

Oregon Programs, Pilots and Proposals of Integrated and Coordinated Care

The Study Group was presented with several pilot programs and initiatives related to the coordination and integration of care in Oregon. These pilots and initiatives included:

- Oregon’s PACE Program. This program offers coordinated health care and LTSS for approximately 1,000 individuals aged 55 and older in Portland. Almost all PACE participants are eligible for both Medicare and Medicaid.¹¹
- Collaborative work between a local Area Agency on Aging (AAA, Lane Council of Governments Senior and Disability Services) and a local CCO (Trillium). This collaborative work extends to AAA-CCO work on sharing information (including hospitalization), transitions to HCBS, and planning for Oregon’s Health System Transformation.
- Trillium’s Institutional - Special Needs Plan (I-SNP) for individuals in institutional and home- and community-based care. The I-SNP model offers a disciplined model of care that can help pattern better integration.¹²
- A pilot between a local managed care organization (CareOregon) and a local office (Washington County Disability, Aging, & Veteran Services)

¹¹ “Providence ElderPlace Portland,”

<http://www.oregon.gov/dhs/cms/Meeting%20files/PACE%20Presentation%20-%20May%202013.pdf>, accessed October 21, 2013.

¹² “At the Table.” <http://www.oregon.gov/dhs/cms/Meeting%20files/Trillium%20Presentation.pptx>, and “ISNP – Our Experience,” http://www.oregon.gov/dhs/cms/Meeting%20files/ISNP_Our_Experience.pdf, both accessed October 21, 2013.

that coordinates care for consumers in a community-based care setting through a co-located interdisciplinary team.¹³

- The Neighborhood Housing and Care Project, an initiative administered by Our House, a residential care facility, which is a community program that integrates health and social services for individuals with HIV/AIDS so that consumers can remain in their own homes and prevent or delay the need for higher levels of care.¹⁴
- Cedar Sinai Park’s Housing with Services proposal model of care and services for seniors and people with disabilities. In this model, consumers live in their own apartments in close proximity, and health care and LTSS services are provided at or near where the consumer lives.¹⁵
- Bridges to Care, a recently-launched pilot project between a CCO (Family Care), an AAA (Multnomah Aging and Disability Services), and union-represented home care workers (ADDUS, whose workers are represented by the Service Employees International Union, Local 503). This pilot program will provide coordination of health care and services for the consumer through the CCO and a highly-trained home care workforce.¹⁶

National and State Data

The Study Group reviewed national and state data regarding Oregon’s LTSS and health systems. One source was the “Raising Expectations” scorecard report published by the AARP Public Policy Institute, The Commonwealth Fund and The SCAN Foundation. It provided rankings for state LTSS programs and placed

¹³ “CareOregon/APD Long Term Care Pilot,”

<http://www.oregon.gov/dhs/cms/Meeting%20files/CCO%20Subcommittee%20LTC%20presentation%20June%201%202013x.pdf>, accessed on October 21, 2013.

¹⁴ “Neighborhood Housing and Care Project,”

<http://www.oregon.gov/dhs/cms/Meeting%20files/Neighborhood%20Housing%20and%20Care%20Project.pdf>, accessed on October 21, 2013.

¹⁵ “Housing with Services Initiative: Project Update,”

<http://www.oregon.gov/dhs/cms/Meeting%20files/Housing%20with%20Services%20Presentation%20-2.pdf>, accessed on October 21, 2013.

¹⁶ “Bridges to Care Project: Empowering, Connecting, Working Together for Better Health,”

<http://www.oregon.gov/dhs/cms/Meeting%20files/09-02-2013%20BTC.pdf>, accessed on October 21, 2013.

Oregon third nationally behind Minnesota and Washington.¹⁷ Another report, America's Health Rankings, evaluated senior health outcomes by state and ranked Oregon fifteenth.¹⁸ From these national surveys, the Study Group determined that Oregon could improve its health outcomes on several indicators including:

- Receipt of flu shots;
- Depression screening;
- Alcohol and substance use treatment;
- Medical care provided at facilities;
- Nutrition; and
- Prevention of pressure ulcers.

To assist the Study Group's discussion, staff produced a factsheet that provided information on the demographics, costs, and administration of Oregon's LTSS system and health system under CCOs.¹⁹ The Study Group also partnered with Oregon's volunteer Long Term Care Ombudsman program to conduct a small survey of new consumers of community-based services regarding the current status of health care and LTSS coordination and outcomes. One preliminary finding was that individuals who felt they did not have a choice in the setting in which they received services reported negative responses when asked whether their providers care about their goals and desires and actively involve them in planning for their health and LTSS services.²⁰

¹⁷ S. Reinhard, A. Houser, and R Mollica. *Raising Expectations: A State Scorecard on Long Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. AARP, September 2011.

¹⁸ UnitedHealth Foundation. America's Health Rankings: 2013 Senior Report. Available at: <http://www.americashealthrankings.org/senior>.

¹⁹ Factsheet on Medicare and Medicaid Services for Individuals Who Receive Long Term Services & Supports, <http://www.oregon.gov/dhs/cms/Meeting%20files/Fact%20Sheet%20on%20LTSS%2007-02-2013x.pdf>, accessed on October 21, 2013.

²⁰ Preliminary Study of New Entrants to Long Term Services and Supports in Oregon's Community Based Care Settings, <http://www.oregon.gov/dhs/cms/Meeting%20files/Consumer%20survey%20resultsx.pdf>, accessed on October 21, 2013.

State Integration Models

The Study Group examined the growth of MLTSS programs. States create MLTSS programs for several reasons. Some state legislatures regard MLTSS as a way to control and sustain LTSS budgets over a long period of time. In other states, MLTSS programs are seen as a mechanism to get more LTSS consumers out of institutional care and into home- and community-based settings. Finally, states may pursue MLTSS programs as a means to deliver better quality services – both medical services and LTSS services. Because Oregon already serves 84 percent of LTSS consumers in home- and community-based settings, the Study Group decided to look at the MLTSS programs of those states that have a similar percentage of consumers in HCBS, as well as states seeking sustainability of LTSS budgets over a long period of time.

The Study Group also discovered that MLTSS programs typically do not cover the entirety of a state’s LTSS programs. Some states typically enroll certain populations (such as consumers age 65 and older), or carve out other populations. States vary as to whether consumer enrollment in MLTSS is mandatory or voluntary, and whether voluntary enrollment gives consumers the ability to opt-in or opt-out of enrollment. Further, state programs may either have plans take on the full risk of LTSS costs or have a shared risk and cost savings arrangement with the state. Underlying the justification for MLTSS programs are financial incentives to encourage person-centered, high quality care and use of HCBS and to control against cost-shifting between providers and systems.

With the understanding that nearly all states (except Arizona) have only part of their LTSS systems under managed care, the Study Group examined a list of best practices gleaned from states with MLTSS programs:

- MLTSS programs should have a clear vision and retain the core values of a state’s LTSS program;
- Stakeholders are engaged early and often in designing the state MLTSS program;

- Effective MLTSS programs use a uniform assessment tool – consumers are screened using universal criteria in order to determine the consumer-centered services;
- MLTSS benefit structures are designed to deliver the right services and care for the populations they serve;
- Attendant care and/or family caregivers are incorporated in MLTSS program design;
- Plans within state MLTSS programs are designed to ensure that needs are met and person-directed/centered interdisciplinary teams are used for care coordination;
- MLTSS programs are designed with the recognition that risks may be adjusted over time, as there is very little actuarial experience with MLTSS programs;
- MLTSS program goals include incentives for higher use of HCBS, and rates are set to make this goal realistic;
- MLTSS programs have robust oversight and monitoring mechanisms, including new performance measures on top of medical/health metrics; and
- MLTSS programs develop LTSS-focused performance measures.²¹

These best practices are not an exhaustive list, nor are all necessarily appropriate for a given state. They do, however, constitute options for Oregon’s consideration of other state models of integration, acknowledging that for many states these efforts also are meant to achieve a rebalancing of systems modeled after Oregon.

In discussing the models and practices of other states, the Study Group identified several considerations for better coordination of health and LTSS services in Oregon. These considerations include:

²¹ A. Lind, S. Gore, and S. Somers. *Profiles of State Innovation: Roadmap for Rebalancing Long Term Supports and Services*. Center for Health Care Strategies, November 2010. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261188

- Looking to best practices from Oregon programs/initiatives, pilots and proposals and other states – such as Minnesota, New Mexico, Washington, and Wisconsin – with similar HCBS populations in their LTSS programs;
- Focusing on care coordination among providers and with consumer participation;
- Accounting for cost drivers in the medical and LTSS systems, as well as any cost shifting that can be prevented through care coordination; and
- Exploring the role of Medicare in care coordination, including the possibility of sharing savings of not only Medicaid costs, but Medicare costs as well.

The following were identified as necessary components of a model that effectively coordinates and integrates the LTSS and medical systems:

- Effective means to identify and provide care coordination to high-risk consumers;
- A key role for care coordination;
- Use of interdisciplinary teams and communication among team members, including the consumer;
- Use of statutorily-defined (House Bill 3650 of 2011), traditional health workers, social service workers, and others to foster consumer engagement;
- Better access to providers and 24/7/365 telephone access to prevent inappropriate hospitalizations of home- and community- based LTSS consumers;
- Flexible use of funds and shared savings for reinvestment in care coordination and flexible services; and
- Strong principles of consumer choice and empowerment, including robust end-of-life supports and services for consumers and their families.

Study Group members started with their individual perspectives and unique rankings. This was followed by group discussion and dialogue, which led to general consensus on many points; however, the facilitation approach attempted to honor individual viewpoints and not to achieve consensus at the risk of impeding diversity of opinion.

Strategies and Outcomes: Working through Straw Models

With these considerations in mind, the Study Group evaluated and discussed two sets of straw models: one general and one Oregon-specific. Each set of models consisted of a continuum of five individual models, ranging from a model with no coordination or integration of the medical and LTSS systems, to a model of full integration of medical and LTSS systems. Each model contained a description of the following domains:

- Care coordination and care teams;
- Financing and contracting;
- Performance and quality measurement;
- Data and information sharing;
- Stakeholder engagement;
- Consumer engagement; and
- Medicare.

For the general set of models, an iterative process was used as each Study Group member ranked where they thought Oregon was on a continuum of integration. Members then participated in extensive dialogue regarding the level of integration to which Oregon should aspire. The results of this iterative process are provided in Appendices II and III.

The Oregon Model Framework for Integration and Coordination

This framework represents the work of Oregon’s 2013 Study Group. It is intended to help foster greater integration between the CCO and LTSS systems while strengthening Oregon’s ORS 410 values and Oregon’s Triple Aim. It also attempts to address the fragmentation that currently exists for many low-income Oregon residents who use Medicaid and other publicly-funded medical care, behavioral health care, and LTSS. The Study Group acknowledges that the outcomes presented require change across many payers and providers, not all of whom were represented in the Study Group.

The task before the Study Group was not simple. One of the thorny issues that arose was to define the population the model is trying to address: Medicaid-only consumers of LTSS and CCO services, consumers dually eligible for Medicare and Medicaid, or high-risk/high-needs consumers. Some of the strategies discussed do not fit all of these populations.

The proposed framework is presented as a series of outcome statements that together represent the Study Group’s definition of integration. While not every outcome articulated within the framework is embraced by all Study Group members, they agree that it is inclusive of the majority while representing multiple viewpoints. In order to maintain a consumer-focused perspective in the model framework, each of the domains listed above had a consumer perspective that summarized the elements of these domains (Exhibit 1).

Majority opinions were expressed throughout the Study Group meetings that certain aspects of the current system should be protected, for example:

- LTSS funding should be commensurate with current projected population and service needs and sustainable, and funds devoted to LTSS should not be mingled or blended with funds for other healthcare services;
- Priorities for LTSS users should be guided by previously articulated values, such as ORS 410 and the Oregon Triple Aim; and
- Beneficiary protections should be maintained and/or strengthened.

Discussion of each domain's elements included alternatives considered but not adopted in the final Oregon model for coordination and integration. In each of the domains, careful thought and discussion centered on feasibility, consumer outcomes, local flexibility, and accountability mechanisms to ensure better consumer outcomes.

Care Team/Care Plan and Coordination across Providers

The Study Group adopted a framework informed by the values of ORS 410 and Oregon's Triple Aim and in which appropriate independent providers and the consumer or consumer's representative participate on the care team.. Discussion considered several alternatives regarding the entity responsible for care coordination, as well as the primary consumer point of contact. Oregon's medical system also relies on Patient Centered Primary Care Homes, and this role contributes to the care coordination model. The group agreed that the responsible entity would be determined by local flexibility, risk bearing responsibility, and capacity and knowledge of the individual's needs. Further, after initially establishing a single point for consumer contact, the aspiration would be for a system of care coordination in which the consumer and provider would have "no wrong door" for contact for care team planning, implementation, and emergencies in the future. Given the varying capacity of different areas of the state, local areas may initially establish care teams and planning for consumers with a higher level of care and service needs. In areas with little capacity for intensive care coordination and/or management, targeting those at high risk is essential. The Study Group agreed to local flexibility in standards for coordinated care, with a focus on targeting limited resources while addressing consumer outcomes.

Exhibit 1: Domains in Oregon’s Integration Framework

Domain	Consumer Perspective of Oregon’s Coordinated and Integrated System
Care Team/Care Plan and Coordination across Providers	All people involved in my care treat me with dignity and respect. I am a valued member of the interdisciplinary team, and my choices for care and services are honored. The team coordinates across systems and providers to ensure that I receive the necessary and appropriate care, services, and supports, which lead to improved health outcomes and quality of life.
Financing/ Contracting	My government and my providers are accountable and transparent regarding the funding they expend on health and social services to serve Oregonians with the necessary and appropriate quality of care and services, while respecting individual choice, dignity, and independence.
Performance, Quality Measurement and Monitoring	State health and social services are monitored to ensure that I get the best quality of care, and quality results are reported so that I can make the best informed choices among providers, services, and care options.
Data and Information Sharing	My personal health/LTSS information is available to my providers as needed in order to provide the best care and services, and there are protections in place about sharing my personal health information. My personal health information is available to me and those family members/other individuals that I designate in a secure, accessible, electronic format. The responsibility for developing this system is shared.
Public and Stakeholder Engagement	The public has multiple avenues for participation and input in my community and at the regional and state levels, and there are multiple ways for the public and stakeholders to meaningfully participate.
Consumer Engagement	My service providers respect my dignity, choices, and values, and I have access to education and information that allow me to make the best choices for my care.
Medicare	As someone who is Medicare and Medicaid eligible, I have seamless access to all services, enrollment is easy, and I have the highest level of rights in grievances and appeals.

Financing and Contracting

The Study Group discussed the alternatives of an integrated budget, as well as a conceptual “virtual global budget.” Virtual global budgeting is a concept in which health and LTSS systems are funded and administered separately, yet have a fixed rate of growth, and both systems are tied to a common set of incentives and financial penalties. These models of financing were considered and discussed in the Study Group, but in the end, rejected by the majority of members. Some Study Group members expressed interest in exploring these concepts further, and one avenue of exploration may be through existing state systems (perhaps through follow-up work of the Shared Accountability Sub-Committee); a majority expressed opposition and favored a shared accountability approach to financing coordination of LTSS and health care. Study Group members raised concerns regarding pooled and braided financing mechanisms because each system was subject to different rates of growth and some services would be vulnerable to this difference. The Study Group did accept other mechanisms of shared accountability between the health and LTSS systems, including incentives and penalties, shared savings, monitoring and addressing inappropriate cost shifting, monitoring the total cost of care per person, and the prioritization of care coordination for individuals with high costs of care and services.

Performance, Quality Measurement, and Monitoring

The Study Group acknowledged that performance and quality metrics underpin an effective system of coordination and integration, while acknowledging that these metrics must be actionable, not overly burdensome, and above all, focused on consumer outcomes. The Study Group agreed that these tools must prioritize consumer outcomes, including measures for consumer satisfaction and experience with care. They also agreed that metrics would drive a coordinated system of shared accountability, savings, incentive payments and penalties, and would use risk-adjusted methods when appropriate.

Data and Information Sharing

Discussion in this domain centered around several issues: capacity and feasibility of data collection and analysis; access to data by consumers, providers, and other entities; timeliness of data and information sharing; and protection of consumer-level data. The Study Group agreed that an effective system of care coordination required better access to real-time data across providers, better access to Medicare data, and strong consumer protections against inappropriate data sharing. Data analysis in an effective system of care coordination would underscore better care coordination for high cost consumers, better preventative planning at the aggregate level, and stronger predictive modeling for improving the overall care coordination system.

Public and Stakeholder Engagement

In creating an effective environment for public and stakeholder engagement, the Study Group agreed to a framework in which there would be meaningful participation through robust governance structures at the state and local level for public and stakeholder input, as well as timely feedback in response to such input.

Consumer Engagement

The Study Group agreed that the consumer or the consumer's representative needed to be an active member of the care team. As such, materials and information for consumers should be consistent, coordinated, and provided in language appropriate to the consumer. Like the public and stakeholders, consumers in a coordinated and integrated system should have access to the governance structures listed above, including local consumer advisory councils. In addition, it was suggested that consumers be engaged and activated in their own health care.

Medicare

Related to all domains above was the issue of Medicare. Most of the consumers in this system of care coordination are eligible for both Medicare and Medicaid. One consideration discussed thoroughly was the barrier to coordination if

Medicare was the primary payer for medical services. Other considerations included misaligned enrollment, grievance, and appeals processes between Medicaid and Medicare. The Study Group agreed to principles in which individuals dually eligible may have integrated consumer materials and grievance and enrollment processes, as well as the importance of further exploration into Medicare Advantage Special Needs Plans (MA-SNPs) as a way to further strengthen care coordination. The Study Group also agreed to a framework in which the total cost of care – including Medicare costs – could be monitored, with the possibility that shared savings – including savings to Medicare – may be shared in the future.

The detailed description of the framework is found in Appendix III.

Timeline

As part of this report to CMS, Oregon staff put together a timeline describing when some activities may occur (Exhibit 2). The Study Group did not have adequate time to explore these ideas in depth, but they are offered here for future consideration by stakeholders. For each domain in the framework, the following considerations were offered for which elements could be accomplished in the near-, mid-, or long term. Given Oregon's commitment to health system transformation, current demands and opportunities, and uncertainty regarding future resources, any timeline needs to be adequately flexible to continue to move both the LTSS and health care systems towards desired outcomes. The leadership of state agencies will determine priorities and convey initial principles underlying improved care planning.

Exhibit 2: Timeline for Integration Activities

Domain	Timeline Considerations		
	Near-Term	Mid-Term	Long Term
Care Team/Care Plan and Coordination across Providers	<ul style="list-style-type: none"> ▪ Monitor current pilots of improved care planning/ coordinated care team models to identify best practices ▪ Use coordination and care teams to ensure continuous improvement around care 	<ul style="list-style-type: none"> ▪ Outline coordination standards (developed by state with stakeholder input) ▪ Develop statewide training program 	<ul style="list-style-type: none"> ▪ Link locally-flexible, statewide standards with accountability mechanisms as needed ▪ Assess readiness before implementation
Financing/ Contracting	<ul style="list-style-type: none"> ▪ Develop data systems to identify high-risk/high-needs users; shared information platforms for care management ▪ Develop high level financial model, shared savings mechanisms, and begin analytic work for shared accountability 	<ul style="list-style-type: none"> ▪ Establish baseline costs ▪ Continue financial modeling, shared accountability framework, and shared savings mechanisms ▪ Develop any necessary contract language ▪ Develop readiness criteria ▪ Identify barriers for shared accountability, shared savings mechanisms, and Medicare/ Medicaid alignment ▪ Identify/apply for CMS or legislative authority, if needed 	<ul style="list-style-type: none"> ▪ Implement shared accountability framework and shared savings mechanisms

Domain	Timeline Considerations		
	Near-Term	Mid-Term	Long Term
Performance, Quality Measurement and Monitoring	<ul style="list-style-type: none"> Elicit stakeholder input on potential LTSS metrics Establish accountability for achieving performance goals 	<ul style="list-style-type: none"> Establish baselines of performance measures Develop contract language for reporting data and/or measures, shared accountability, and shared savings mechanisms 	<ul style="list-style-type: none"> Introduce requirements into contracts as needed Begin reporting
Data and Information Sharing	<ul style="list-style-type: none"> Engage stakeholders on the needs and requirements for a shared information efforts Plan around information sharing to facilitate a coordinated care system 	<ul style="list-style-type: none"> Begin data reporting and refine reporting process Develop short-term solutions and easy wins to support coordinated care Plan for long-range data utilization 	<ul style="list-style-type: none"> Evolve efforts for shared information sharing Begin reporting of integrated data analysis Implement care coordination information sharing infrastructure Implement long-range plan for data integration and analytics
Public and Stakeholder Engagement	<ul style="list-style-type: none"> Plan for ongoing stakeholder input into model development and implementation at the state and local level 	<ul style="list-style-type: none"> Develop continuous feedback loops to stakeholder and public input at the state and local levels 	<ul style="list-style-type: none"> Ensure ongoing involvement of stakeholders during implementation
Consumer Engagement	<ul style="list-style-type: none"> Plan for model elements to be included Develop consumer education and materials 	<ul style="list-style-type: none"> Support pilots for consumer engagement on care teams and ways to promote self-care 	<ul style="list-style-type: none"> Implement model elements Share and disseminate best practices of consumer engagement statewide

Domain	Timeline Considerations		
	Near-Term	Mid-Term	Long Term
		<ul style="list-style-type: none"> Establish consumer feedback to systems changes at the state and local levels 	
Medicare	<ul style="list-style-type: none"> Identify barriers and benefits for shared savings strategy with Medicare Advantage Special Needs Plan flexibility Continue integration/alignment activities 	<ul style="list-style-type: none"> Establish baseline costs for dual eligibles and high cost utilizers Develop partnership with plans for any new, potential alignment strategies Integrate Medicare data into analytic data systems 	<ul style="list-style-type: none"> Engage in fuller implementation of alignment strategy and implementation of shared savings strategy with Medicare

Shared Accountability

Early in its deliberations, the Study Group recognized the critical importance of a clearly-defined plan for shared accountability between CCOs and LTSS. Measures of a more coordinated system are notoriously lacking in uniform standards despite efforts on a national level to identify measures that are important to consumers, including those of care coordination, quality of life, and outcomes in a person-centered plan of care.²² Absent standard measures for such priorities and local stakeholder concerns about preserving consumer values, the Study Group recognized the need for a more intensive, comprehensive study on shared accountability. As a result, a Sub-Committee was formed to focus on this work and bring recommendations to the full Study Group.

Major accomplishments of the Shared Accountability Sub-Committee include:

- Agreeing to start from previous accomplishments from workgroups over the past several years. For example, in support of the CCO model and the Dual Eligible Demonstration;
- Creating a framework for evaluating potential metrics;
- Researching and exploring national measures to inform local recommendations;
- Creating recommendations for CCO reporting at a subpopulation level for people whose eligibility is related to aging and disabilities;
- Identifying that shared accountability includes a broader definition of LTSS, not just institutional LTC;
- Proposing an initial draft of LTSS specific metrics including:
 - Percentage of consumers living and dying in their preferred setting
 - Percentage of consumers with an interdisciplinary team in place and an integrated care plan
 - Percentage of consumers with Physician's Orders for Life Saving Treatment and/or Advance Directive completed

²² National Quality Forum Measures Application Partnership. *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*. June 2012. Available at: http://www.qualityforum.org/Publications/2012/06/Measuring_Healthcare_Quality_for_the_Dual_Eligible_Beneficiary_Population.aspx and National Committee for Quality Assurance. *Integrated Care for People with Medicare and Medicaid: A Roadmap for Quality*. March 2013. Available at: http://thescanfoundation.org/sites/thescanfoundation.org/files/ncqa-integrated_care_for_people_medicare_medicaid-3-6-13.pdf

- Total cost of care
- Beginning work across OHA and DHS in metrics development and in understanding and aligning CCO and LTSS measures;
- Modifying the existing timeframe for continuing shared accountability work;
- Aligning and supporting broader stakeholder group input on shared accountability;
- Recommending next steps in shared accountability work including broader stakeholder involvement, especially by current consumers of LTSS services; and
- Agreeing to continue involvement in future shared accountability work beyond the Study Group timeframe.

The full Study Group supported the work of the Shared Accountability Sub-Committee. See Appendix IV for the full report of the Sub-Committee.

Conclusion

DHS and the OHA appreciate this opportunity to discuss, plan, and eventually implement a strategy of coordination and integration of LTSS and health care with this Study Group of stakeholders. This recommended framework is one of many steps toward a system that is more accountable, transparent, and focused on consumer outcomes of better health, health care, and lower costs, as well as consumers living lives with independence, choice, and dignity. In planning for the future of LTSS and Health System Transformation, it is the consumer on whom all of these efforts are based, and DHS and OHA will continue its work with stakeholders as the proposed timeline unfolds. DHS and OHA welcome any feedback CMS may have.

Appendix I: Study Group Roster

Study Group Members:

Ruth Bauman, ATRIO Health Plan, Member of Umpqua Health and WVCHP

Liz Baxter, MPH, We Can Do Better

Donald Bruland, Consumer Advisory Councils for Jefferson Regional Health Alliance, Jackson Care Connect, and AllCare

Carol Burgdorf-Lackes, FamilyCare CCO

Jim Carlson, Oregon Health Care Association

Jerry Cohen, AARP Oregon

Terry Coplin, Trillium Community Health Plan

Stephanie Dockweiler, Malheur County Health Department

Chris Flammang, Coos/Curry Area Aging on Aging Advisory Council

Ellen Garcia, Providence ElderPlace Portland

Mary Guillen, Medical Interpreter

Ruth Gulyas, LeadingAge Oregon

Tim Malone, LCSW, Deschutes County Behavioral Health

Ruth McEwen, Oregon Disabilities Commission

Wayne Miya, Our House of Portland

Meghan Moyer, Service Employee International Union, Local 503

Margaret Rowland, MD, CareOregon

Rodney Schroeder, Oregon Association of Area Agencies on Aging and Disabilities

Tina Treasure, State Independent Living Council

Michael Volpe, Intercommunity Health Network CCO Consumer Advisory Committee

Staff:

Center for Health Care Strategies:

Alice Lind, Facilitator

Brianna Ensslin

Oregon Health Authority and Department of Human Services:

Jeff Scroggin, OHA Lead

Bob Weir, DHS Lead

Max Brown

Selina Hickman

Chelas Kronenberg

Naomi Sacks

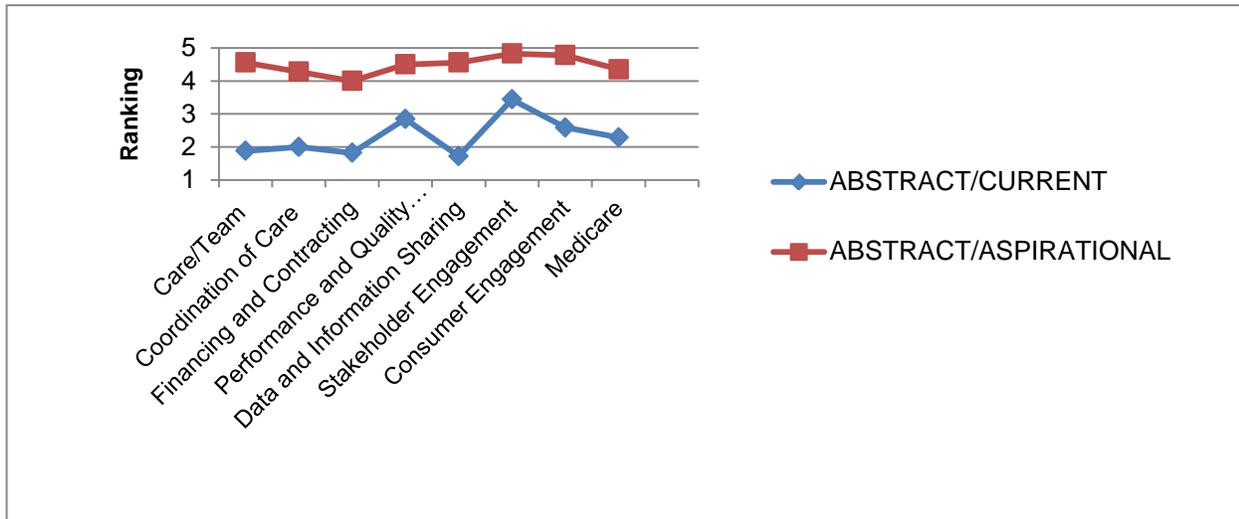
Daniel Amos

Jeannette Hulse

Ann McQueen

Chris Sanchez

Appendix II: Aspiration Rankings of Oregon Straw Model



Appendix III: Oregon's Coordinated & Integrated LTSS & CCO Framework

This framework represents the work of Oregon's 2013 Study Group. It is intended to help lead the way to greater integration and coordination between the CCO and LTSS systems while remaining consistent with and strengthening Oregon's ORS 410 values and Oregon's Triple Aim.

The framework is presented as a series of outcome statements that together represent the Study Group's definition of integration and coordination. Although not every outcome articulated within the framework is embraced by all members of the Study Group, group members agree that this work is inclusive of the majority while representing multiple viewpoints reached through debate and discussion. The Study Group report outlines areas where a key minority opinion was expressed by members of the group.

The Study Group acknowledges that the outcomes presented require change across many payers and providers, not all of which were represented in the Study Group's membership.

For more information on the Study Group please visit:

<http://www.oregon.gov/DHS/cms/pages/index.aspx>

Care Team/Care Plan and Coordination across Providers

- **All people involved in my care treat me with dignity and respect. I am a valued member of the interdisciplinary team, and my choices for care and services are honored. The team coordinates across systems and providers to ensure that I receive the necessary and appropriate care, services, and supports, which lead to improved health outcomes and quality of life.**
- All parties/participants involved with care team planning and implementation shall apply Oregon ORS Chapter 410 values and priorities and use Oregon's Triple Aim in decision making. (Oregon's Triple Aim is to: (1) improve the lifelong health of all Oregonians; (2) increase the

quality, reliability, and availability of care for all Oregonians; and (3) lower or contain the cost of care so it is affordable for everyone.)

- Independent partners (including direct service providers from health and LTSS as well as consumer/consumer representatives) create, develop, and participate in integrated care plans and serve on care teams.
- Duplication and inefficiency are reduced through clearly defined interdisciplinary team roles and responsibilities.
- Local flexibility, risk bearing responsibility, capacity, and knowledge of the individual's needs are criteria used to select the entity responsible for care coordination across providers. Linkage to Patient-Centered Primary Care Homes will be considered when identifying care coordination responsibilities.
- For consumer clarity, there is a clearly identified and communicated point of contact for consumers/consumer representatives and/or advocates to access the care team for planning, implementation, and emergencies (24/7/365) with aspirations to have "no wrong doors" for consumers and providers in the future.
- Clear communication and care coordination is achieved through shared terminology/training that is developed across systems, for example, a single shared care plan.
- Administrative barriers to service delivery are removed to ensure better care coordination across systems (e.g., overcoming CMS payment restrictions on allowing LTSS providers to care for consumers while they are hospitalized).
- The expansion of MA-SNP models, which improve care coordination, is explored through innovative waivers that remove barriers.

Financing/Contracting

- **My government and my providers are accountable and transparent regarding the funding they expend on health and social services to serve Oregonians with the necessary and appropriate quality of care and services, while respecting individual choice, dignity, and independence.**
- High quality services, lower costs, and transparency are improved through care coordination; there is a focus upon identifying and addressing high need individuals.
- Care providers and LTSS staff have the resources they need to fully participate in care planning and service delivery. Resources are prioritized and re-directed to the greatest extent possible, as needed to effectively participate in care coordination, including care conferences.
- Local control is supported through data-driven innovation and contract flexibility, and innovative pilots are encouraged.
- Mechanisms for shared accountability are in place and include, but are not limited to:
 - Performance-based contracting;
 - Incentive payments and penalties;
 - Quality pools;
 - Risk adjustments (based on case mix, etc.);
 - Shared savings;
 - Cost shift monitoring;
 - Cost of care coordination monitoring;
 - Identifying high cost utilizers;
 - Monitoring the total cost of care per person;
 - Alternative payment methodologies; and
 - Developing mechanisms for addressing inappropriate cost shifting.

- The total cost of health care and LTSS, including Medicare, Medicaid and LTSS, is sustainable, accountable and predictable; there is shared responsibility for transparency.
- CCOs, MA-SNPs, the state, AAAs, and both licensed and non-licensed providers (individual and/or union represented) are encouraged to enter into negotiated contracts including but not limited to evidence-based care supports and services, such as case management/coordination for non-LTSS consumer case management/coordination. Barriers to contracting are identified and removed as appropriate.
- MA-SNPs which increase consumer choice, meet Oregon’s Triple Aim, protect the values of ORS 410, and maximize efficiency are supported by federal flexibility and investments for mutual shared savings.
- Oregon will work with its federal partners to seek federal investment and guidance in order to implement this integrated and coordinated shared savings framework.

Performance, Quality Measurement, and Monitoring

- **State health and social services are monitored to ensure that I get the best quality of care, and quality results are reported so that I can make the best informed choices among providers, services, and care options.**
- The quality measures and monitoring tools chosen are consistent with consumer health, choice, independence, and values and priorities across all systems and providers, and they include measures of consumer satisfaction and experience of care.
- Systems are held accountable to aligned metrics that are well-defined, actionable, least burdensome, non-duplicative, and focused on outcomes. Systems have broad flexibility to achieve outcomes.

- Metrics drive a coordinated system of shared accountability, savings, incentive payments, and penalties.
- Risk-adjusted methodology will be applied to compare the performance of responsible entities where appropriate.
- CCOs and LTSS systems are accountable through comprehensive plans, including shared accountability metrics, evaluation, and performance based contracts where appropriate.
- There are quality improvement and performance incentives and penalties aligned across systems, with a focus on flexibility to achieve outcomes.

Data and Information Sharing

- **My personal health/LTSS information is available to my providers as needed in order to provide the best care and services, and there are protections in place about sharing my personal health information. My personal health information is available to me or my designated decision maker in a secure, accessible, electronic format. The responsibility for developing this system is shared.**
- Care coordination, public reporting, and consumer choice are informed by population-level data that are relevant, actionable, and provided in as timely a manner as possible. Data reflects appropriate mechanisms to identify and minimize cost shifting and to improve outcomes.
- Trends are identified through analysis, and prevention programs are implemented on the basis of data that are proactively used and shared within and between each system. Data analysis is comprehensive, and encompasses LTSS, CCO, and provider information.
- The state can better understand and share information about complex utilization patterns through access to Medicare Advantage and Medicare

Part A, B, and D data, as well as real time information on high cost utilization services such as hospital, emergency department, and inpatient hospital stays. There is a recognized need for shared responsibility for data collection.

- The state and stakeholders develop a long-range plan for data integration and collection, including: cost, quality, clinical, outcomes, and utilization which is comprehensive and features updates in real time when feasible. Integrated, comprehensive data is accessible to consumers, providers, health plans, CCOs, advocates, and the public, within privacy guidelines, and this data may be used for predictive modeling.

Public and Stakeholder Engagement

- **The public has multiple avenues for participation and input in my community and at the regional and state levels, and there are multiple ways for me to meaningfully participate.**
- Meaningful public engagement is supported through APD/AAA local offices, CCOs' local and state governance structures, including advisory councils, and public meetings held at the local and state level. Each structure is responsible for establishing timely feedback mechanisms to the engaged public.
- Stakeholders are encouraged and invited to be fully engaged and participatory through policy-making and implementation processes.

Consumer Engagement

- **My service providers respect my dignity, choices, and values, and I have access to education and information that allow me or my designated decision maker to make the best choices for my care.**

- The consumer and/or the consumer's representative are invited to participate in care planning and are active members of the care team.
- Information provided to consumers across CCOs and LTSS shall be coordinated, consistent in content, and provided in consumer-friendly language.
- Consumers are empowered at the systems level by having access to multiple channels for feedback, participation, and input across all systems through the mechanisms of public engagement and feedback described above. Local agreements should reflect consumer participation on advisory councils.
- Systems for continuous quality improvement across LTSS/CCOs integrate consumer feedback obtained through satisfaction surveys, grievance information, advisory councils' reports and other means of understanding delivery shortcomings are used to inform continued system improvement.
- Consumer preferences for health and LTSS are respected, and they have options so they can choose the right care at the right place, at the right time.
- Consumers, CCO's, and LTSS share responsibility for personal health and LTSS outcomes.

Medicare

- **As someone who is Medicare and Medicaid eligible, I have seamless access to all services, enrollment is easy, and I have the highest level of rights in grievances and appeals.**
- Oregon will seek to reduce duplicative and/or inefficient administrative and regulatory burdens related to MA-SNPs.

- Oregon will explore the benefits to consumers of CCOs having or contracting for MA-SNPs for consumers eligible for Medicare, Medicaid, and/or LTSS with enrollment consistent with House Bill 3650.
- Planning and care are improved through tracking, analyzing, and reporting Medicare and Medicaid (including LTSS) claims data.
- Medicare costs are monitored, along with other costs, to understand total spending, to understand and report areas of cost shifting, and to determine opportunities for shared savings and increases in benefit flexibility.
- Oregon will continue its work through the State Innovations Model grant to integrate member materials, align grievances and enrollment processes, and explore other areas of alignment.
- Oregon's Transformation Center will facilitate learning collaboratives that focus on high-cost utilizers. This may include MA-SNP focused collaboratives, which align models of care and spread best practices to coordinate care for those who are dual and triple eligible for Medicaid, Medicare, and LTSS services.

Appendix IV: Shared Accountability Sub-Committee Report

Sub-Committee Formation, Composition, and Goals

Volunteers representing key Study Group stakeholders from medical, social services, consumers and advocates were sought. The final Sub-Committee roster of six stakeholders included consumers, consumer advocates, CCOs and LTSS providers with experience in program evaluation and with pilot programs for ongoing health and LTSS coordination. The Sub-Committee reported and discussed its work as well as obtained approval of its recommendations monthly at the full Study Group meetings.

The Sub-Committee adopted three goals:

1. Identify opportunities, strategies and barriers for monitoring, and evaluation strategies for the coordination model proposed by the Study Group;
2. Provide recommendations for the current shared accountability model and current shared accountability activities including: LTSS/CCO draft metrics and strategies for shared fiscal savings and incentive/penalty models; and
3. Address other tasks the Sub-Committee assigned to itself.

Over the course of its meetings, the Sub-Committee focused on the second goal and completed work on recommendations for sub-population reporting of CCO incentive metrics by LTSS populations and developing draft LTSS centric metrics. Related to the third goal, the Sub-Committee began its work by discussing and adopting criteria for selecting metrics. The Sub-Committee was interested in continuing to meet or being part of future shared accountability workgroups as it was unable to accomplish its first goal since the final version of the coordination model was not completed until after the final Study Group meeting.

Previous Work on Shared Accountability

The Sub-Committee started with agreement to build off of previous shared accountability work in Oregon. This included a Budget Note Workgroup report,²³ a strategic framework for Coordination and Alignment between Coordinated Care Organizations and Long Term Care²⁴ developed as part of a Duals Demonstration grant application and a subsequent internal workgroup developing draft materials on shared accountability. In addition, the group gained an appreciation for earlier work performed and determined their role was to build upon and strengthen earlier developed concepts, including contracts requiring an MOU between LTSS offices and CCOs and the MOUs themselves.

Key Sub-Committee Findings and Discussion

The Sub-Committee began by discussing criteria for metrics and exploring Oregon and national models. Guidance on metric selection was captured in a CHCS-originated document entitled, "Performance Measures Selection Criteria for Shared Accountability" (Appendix V). Stated overarching guiding principles reflected Oregon's priorities of better health, better health care, lower costs; Oregon statute protecting consumer independence, dignity and choice; and LTSS future planning emphasis on right services, right time, and right place. Attributes for selection named were consistent with national trends including being evidence based, important to identifying gaps and areas for improvement, valid, reliable and feasible among other attributes.

The Sub-Committee considered OHA CCO metrics and data reporting, including incentive metrics. The Sub-Committee recommended priorities for CCO incentive metrics to be reported by LTSS sub-populations (older adults and adults with

²³ Oregon Department of Human Services, "Budget Note Report on Oregon's Long Term Care System," January 2012, <http://www.oregon.gov/dhs/aboutdhs/budget/2011-2013/docs/ltc-budget-note-rpt.pdf>, accessed 16 October 2013.

²⁴ Oregon Health Authority, "Strategic Framework for Coordination and Alignment between CCOs and Long Term Care," February 2012, <http://www.oregon.gov/OHA/OHPB/meetings/2012/2012-0214-cco-strategic-framework.pdf>, accessed 16 October 2013.

disabilities).²⁵ Some of the highest priority metrics for sub-population reporting include:

- High cost service use (i.e., emergency department and hospitalization):
- Consumer Assessment of Healthcare Providers and Systems experience of care and health and functional status measures;
- Prevention measures such as flu shots, smoking cessation and initiation and engagement in alcohol and drug treatment;
- Care plans and care transition record transmission; and
- Planning for end of life care.

The emerging but as yet unclear national consensus on LTSS metrics was a topic of Sub-Committee discussion. The Sub-Committee considered and used Stephen Kaye's inventory on Quality of Life measures,²⁶ CMS guidance on MLTSS,²⁷ the State of Health and Aging in America,²⁸ The SCAN foundation LTSS scorecard,²⁹ overview materials from CHCS on national trends in LTSS measurement,³⁰ and other sources to inform their work.

In drafting LTSS metrics, the Sub-Committee weighed the need to reflect performance on the LTSS side around areas of shared accountability, the difficulty

²⁵ The OHA workgroup is defining the population of adults with disabilities to be included in sub-population reporting. In October 2013 it started to define the population of adults with disabilities to be included in sub-population reporting of CCO metrics.

²⁶ H.S. Kaye, *Selected Inventory of Quality of Life Measures for Long Term Services and Supports Participant Experience Surveys*, Center for Personal Assistance Services, University of California San Francisco, December 2012. Funded by the California Department of Rehabilitation (Interagency Agreement #28316) and the National Institute on Disability and Rehabilitation Research (Grant'#H133B080002). Available at: <http://www.dredf.org/Personal-experience-domains-and-items.pdf>, accessed October 23, 2013.

²⁷ National Senior Citizens Law Center, *Summary of CMS Guidance on Managed Long Term Services and Supports*. May 2013. Also available at: <http://www.oregon.gov/dhs/cms/SharedAccountability/Summary%20of%20CMS%20Guidance%20on%20MLTSS.pdf> or <http://www.nslc.org/wp-content/uploads/2013/05/MLTSS-Guidance-052313.pdf>, accessed October 23, 2013.

²⁸ Centers for Disease Control and Prevention. *The State of Aging and Health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2013. Available at http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf, accessed October 23, 2013.

²⁹ AARP, The Commonwealth Fund & The SCAN Foundation, *Raising Expectations: A State Scorecard on Long Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers*. 2011. Available at <http://www.longtermscorecard.org/>, accessed October 23, 2013.

³⁰ A. Lind. "Performance Measures and Metrics: Oregon Subgroup on Shared Accountability."

of measuring some key LTSS factors for which new data collection methods would need to be developed, the need for risk adjustments for small scale LTSS providers to be fairly held accountable and the need to be sensitive to the current, heavy metrics expectations for CCOs.

While the Sub-Committee recognized that there are many significant measures of coordination, identifying a small core set of feasible measures was critical to propose for initial work with the expectation of continued review and evolution over time. These particular measures were of the highest priority for the following reasons. Living and dying in preferred locations addresses and measures performance related to the overarching values of ORS 410, of upholding independence, dignity and choice for older adults and adults with disabilities, which are woven throughout the integration discussion. Care coordination (including interdisciplinary teams and integrated care plans) and financing (including tracking of high service use and cost shifting) were two of the Study Group's key focus areas for integration work.

A final product of the Sub-Committee was to develop a timeline for further development and implementation of shared accountability work.

Next Steps

The Sub-Committee suggested a number of actions to continue shared accountability work including to:

- Seek additional stakeholder input on LTSS metrics, particularly from consumers using LTSS services rather than their advocates;
- Re-convene the Sub-Committee to consider additional stakeholder feedback;
- Present the recommendations of the Sub-Committee to the Metrics and Scoring Committee for integration into OHA and DHS accountability work;
- Continue work with OHA's Health Analytics unit to operationalize sub-population reporting, LTSS metrics and other related work;

- Form a workgroup, either through the SB 21/LTC 3.0 initiative or other means, inviting the Study Group Sub-Committee to participate by continuing to provide guidance on shared accountability tools; and
 - Use this workgroup to: 1) address opportunities, strategies and barriers for monitoring and evaluation approaches for the coordination model proposed by the study group; and 2) provide recommendations on strategies for shared fiscal savings and incentive/penalty models.

Appendix V: Performance Measures Selection Criteria for Shared Accountability Metrics

Overall guiding principles for measure selection are:

- 1) Oregon’s Triple Aim: “Better health, better health care, lower cost”
- 2) ORS 410: Choice, dignity and independence values
- 3) Long Term Care 3.0: “Right services, right time, right place”

Attribute	Description
Importance	<ul style="list-style-type: none"> ▪ Impact on health, costs of care ▪ Potential for improvement, existing gaps in care, disparities
Evidence	Scientific evidence for what is being measured
Validity	Does the measure capture the intended content?
Reliability	Precision, repeatability
Meaningful differences	Is there variation in performance? Is there room for improvement? Include both qualitative and quantitative measures
Feasibility	Susceptibility to errors or unintended consequences (Note that outside expertise may be needed to determine feasibility of potential measures)
Costs of data collection	Burden of retrieving and analyzing data
Usability	Testing to see if users understand the measure <ul style="list-style-type: none"> ▪ Results should be usable as strategies for improving care
Actionable	Results of measurement should be used for quality improvement
Standardized	Measures should be based on national standards and calculated using consistent methods

Appendix VI: Public Comments

This appendix summarizes the public comments received on this draft report.

Date Received	Commenter	Comment
November 16, 2013	Amanda Johnson, Member, Elders in Action Commission on Aging, Health, Security Subcommittee	Dental health services are inadequately covered under the Oregon Health Plan. Please consider structuring dental health benefits to be more comprehensive and based on current practice standards. Both the services provided and coverage limits need to be brought into parity with physical health services. Plan language should also be written in a way that is understandable to consumers.
December 2, 2013	Jim McConnell, Chair, United Seniors of Oregon and Steve Weiss, Chair, Oregon State Council for Retired Seniors	<p>This report to CMS should:</p> <ul style="list-style-type: none"> ▪ Challenge the assumption that integration of LTC services and budgets under the CCOs would improve the delivery of health care or LTC services to the consumer; ▪ Request that Oregon’s LTC system remain intact while changes are made to its health care system; ▪ Support the creation of seamless linkages between the health and LTC systems (e.g., care management teams; health care access to the LTC services and supports for the functions of daily living; LTC access to health care consultants, prevention and treatment services in community settings); ▪ Support collaborative DHS and OHA planning to connect and

		<p>coordinate services between the health and LTC systems, rather than LTC being absorbed by the medically-oriented CCO system;</p> <ul style="list-style-type: none">▪ Assure that the CCO model in Oregon meets basic community standards for collaborative planning and development e.g. strong consumer involvement, transparency in policy and budgeting decisions; and▪ Request a waiver to allow Oregon to develop a “collaborative” model rather than an “integration” model of service and accountability to assure the highest quality of community living for consumers of the system.
--	--	--

2014 Medicaid Advisory Committee Meetings

January						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

March*						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June**						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

September						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

October						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

November						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	TDB	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

December						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	TDB	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

***** March meeting being held at PSOB; 800 NE Oregon St, Room 1E; Portland

****** June meeting being held at 29353 SW Town Center Loop E; Wilsonville

Yellow All other meetings being held at 1225 Ferry St SE, Mt. Mazama Room; Salem



The Impact of Insurance Coverage on Low-Income Adults: The Oregon Health Study

BACKGROUND

In early 2008, Oregon began randomly selecting a limited number of individuals from a reservation list to fill openings in its Medicaid expansion program. This presented an unprecedented opportunity for researchers to evaluate the causal effects of insurance on health care, financial strain, and health – bringing the scientific rigor of randomized controlled trials to bear for the first time on these crucial policy questions. The Oregon Health Study (OHS) is designed to take advantage of this unique opportunity to assess the true effects of expanding access to health insurance.

WHY DO A STUDY?

The Chance to Provide Superior Causal Evidence: Researchers and policymakers have long wanted to understand the real impacts of health insurance coverage, but these questions are usually very difficult to answer: People with and without insurance differ in many ways that may affect health, so comparing the health outcomes of the insured to the uninsured may not tell us the effects of insurance itself. While many researchers have used statistical tools to mitigate this fundamental problem, the only way to know if insurance *causes* improved outcomes is to randomly assign health insurance coverage to some but not others, so that there are no other systematic differences between the uninsured and the insured groups. While this would normally not be feasible, the lottery in Oregon created just such a circumstance.

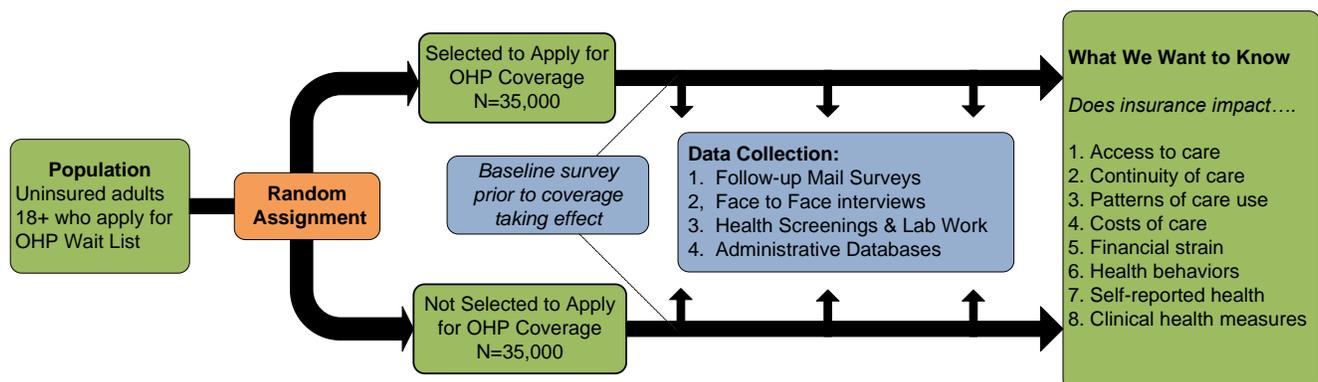
Important & Timely Research Questions: In light of the ACA's coverage expansions, and with many implementation questions still ahead, it is more important than ever to understand what insurance actually does. OHS can tell us about the causal impacts of insurance on:

- **Health Care Use:** How does insurance affect the amount of health care that people receive? Improve efficiency of delivery and patterns of health care use?
- **Health Outcomes:** Does insurance improve health? The management of chronic disease?
- **Financial Security:** Does insurance protect families from financial strain? Reduce bankruptcies and collections?
- **Disparities:** Are the effects of insurance different for diverse and vulnerable populations?

STUDY DESIGN

Overall Design: OHS formed a statewide panel of 70,000 individuals from the reservation list: half whom were selected in the 2008 coverage expansion and half whom were not. The entire panel was surveyed at the time of selection and then prospectively followed going forward.

The Oregon Health Study: Research Design



OHS draws on four distinct data sources, providing highly complementary information to paint a rich and robust picture of the many different effects of insurance.

Phase 1: OHS conducted a longitudinal mail and telephone survey of 70,000 individuals, half of whom were selected in the lottery and half of whom were not. All panel members were surveyed at baseline (before their insurance begins), then again twelve months later to assess changes in their health and health care experiences.

Phase 2: Approximately 18-24 months after the 2008 lottery, a subset of individuals from the main panel were selected to receive an intensive follow-up with two key elements: (i) a comprehensive in-person interview collecting much more detailed data, and (ii) a series of clinical health measures (such as blood pressure, cholesterol, diabetic blood sugar management, obesity) collected via physical exams. OHS completed nearly 13,000 such health interviews/screenings.

Phase 3: OHS collected administrative data for everyone on the reservation list from many different sources, including statewide hospital utilization data, ED visit data, mortality data, and credit report data. All data were de-identified for analysis to protect confidentiality.

Phase 4: Finally, OHS conducted over 800 qualitative interviews with participants from the study. These semi-structured interviews were designed to go “behind the numbers” to provide context to survey results and a more complete understanding of how insurance (or the lack of it) impacts participants’ lives.

PROGRESS

Data collection was completed in 2011. Three sets of results have been released to date; in the *Quarterly Journal of Economics*, the *New England Journal of Medicine*, and the journal *Science*. More are planned.

STUDY PARTNERS

The Oregon Health Study was designed and run by a team of investigators who represent a unique inter-institutional and multidisciplinary partnership.

- In Oregon, *Providence Health System’s Center for Outcomes Research & Education (CORE)* was responsible for fielding the study, and is also home to Principal Investigator Bill Wright, PhD.
- *Columbia University* is home to Principal Investigator Heidi Allen, PhD.
- *NBER, the National Bureau of Economic Research*, is home to three Principal Investigators: Katherine Baicker (Harvard); Amy Finkelstein (MIT), and Sarah Taubman (NBER).

Other key study partners include OHREC (The Oregon Health Research and Evaluation Collaborative), the Oregon Office of Health Policy and Research (OHPR), and the Department of Medical Assistance Programs (DMAP) in Oregon.

STUDY FUNDING

OHS was funded with a combination of private foundation and federal grant dollars. The commitment of early funding from Foundations was vital to the project’s success, including generous support from the Robert Wood Johnson Foundation, the Sloan Foundation, the MacArthur Foundation, the Smith-Richardson Foundation, and the California Health Care Foundation. OHS also received support via federal research grants through National Institutes of Health (NIH), the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services, and the Social Security Administration.

CONTACTS

If you have any questions or want more information about the Oregon Health Study, please visit the study’s web site at www.oregonhealthstudy.org or contact one of the study’s Principal Investigators:

Bill Wright
Providence Health & Services
503-215-7184
Bill.Wright@providence.org

Katherine Baicker
Harvard School of Public Health
617-432-5209
kbaicker@hsph.harvard.edu

