Oregon Health Authority

Coordinated Care Organizations

Implementation Proposal

House Bill 3650
Health System Transformation
January 24, 2012

www.health.oregon.gov

Oregon Health Policy Board

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Coordinated Care Organization (CCO) Implementation Proposal
House Bill 3650 Health Care Transformation

1. Executive summary

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

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

- Integration and coordination of benefits and services;
- Local accountability for health and resource allocation;
- Standards for safe and effective care; and
- A global Medicaid budget tied to a sustainable rate of growth.

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

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

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

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

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

Financial projections for greater system efficiency and value
There is ample evidence from initiatives in our local communities that the kind of transformation pointed to by HB 3650 can improve health outcomes and lower costs. National efforts show the same results.

Included in the proposal is work conducted on behalf of OHA and the Oregon Health Policy Board by Health Management Associates (HMA) that estimates total Medicaid spending in Oregon can be reduced by over $1 billion in the next three years and $3.1 billion over the next five years. In year one, the savings equate to $155 million to $308 million in total fund ($58 million to $115 million general fund) cost reductions, net of new investment. HMA believes these projections are conservative as there are certain opportunities that would move the system beyond what we currently understand as well-managed. It is also possible that greater potential savings could be achieved with faster implementation. Full details of HMA's analysis are included in the proposal.

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

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

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

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

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

- *Application process*: Beginning in spring/early summer of 2012, prospective CCOs will respond to a non-competitive request for applications (RFA) much like the process developed by the federal government for Medicare Advantage plans. The RFA will describe the criteria outlined in this proposal that organizations must meet to be certified as a CCO, including relevant Medicare plan requirements. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

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

- *CCO criteria*: In their applications for certification, CCOs will demonstrate how they intend to carry out the functions outlined in HB 3650 including *(See Appendix D)*:
  - Ensuring access to an appropriate delivery system network centered on patient-centered primary care homes;
  - Ensuring member rights and responsibilities;
  - Working to eliminate health disparities among their member populations and communities;
  - Using alternative provider payment methodologies to reimburse on the basis of outcomes and quality;

- Developing a health information technology (HIT) infrastructure and participating in health information exchange (HIE);
- Ensuring transparency, reporting quality data, and;
- Assuring financial solvency.

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

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

Timeline

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

Additional information and resources about Medicaid transformation and CCOs can be found at: www.health.oregon.gov.

2. Existing market environment and industry analysis

Target population

Projected enrollment

The target population includes all current and future Oregon Health Plan (OHP) enrollees. Between 2010 and 2011, enrollment grew rapidly, due primarily to growth within the expansion group. OHP staff estimates project modest (3%) annual enrollment growth through state fiscal year 2014, followed by a rapid increase between 2014 and 2015 when the Affordable Care Act Medicaid expansion goes into effect. (See Figure 1) While the vast majority of new enrollees are expected to be non-disabled adults, OHP is projecting that the annual rate of growth among the disabled and dual-eligibles, which is approximately 6 percent (excluding the year of the Medicaid expansion), will be roughly three times that of the TANF-related population's 2 percent. This trend is critical, as the disabled and dually eligible populations are, on average, far more costly than their TANF-related counterparts, and also stand to benefit most from effective care management.

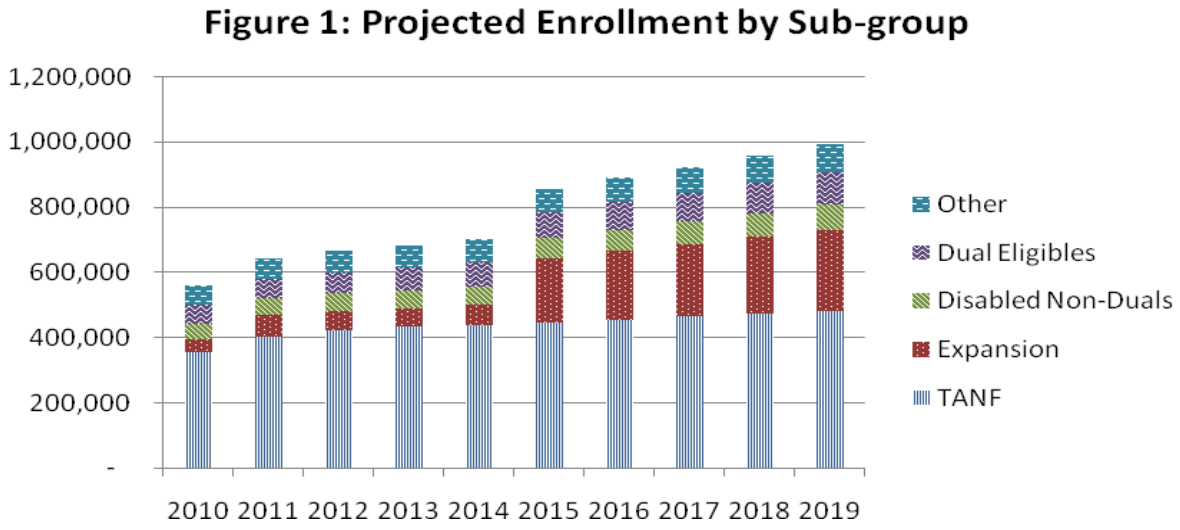

Table 1 shows the demographic distribution of the Oregon Medicaid population in 2011. The racial/ethnic makeup of the population has remained virtually unchanged over the last three years. The age profile of the Oregon Medicaid population has also remained stable over the last three years, though there has been a slight shift from the 0–18 age group to the adult group. This trend is expected to be much larger beginning in 2014, as the majority of new Medicaid enrollees will be previously uninsured adults. Approximately 56 percent of Medicaid enrollees are women and 44 percent are men. While this distribution has remained constant over the last several years, it is expected to shift somewhat toward men when the 2014 expansion is implemented.

Table 1: Oregon Medicaid Demographics (2011)

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

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

Current delivery system for target population

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

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

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

[1] Oregon Health Authority. Oregon Health Policy Board meeting slides, Jan. 18, 2011

Population characteristics and health status

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

- *Perinatal indicators.* Maternal and child health indicators are important factors in assessing the relative health of a community. Risk factors for poor birth outcomes such as low birth weight, short gestation, maternal smoking, inadequate maternal weight gain during pregnancy and substance abuse can often be addressed as a woman receives prenatal care.
- *Chronic conditions.* Experts estimate that chronic diseases are responsible for 83 percent of all health care spending.[2] Health care spending for a person with one chronic condition on average is 2-1/2 times greater than spending for someone without any chronic conditions.[3]
- *Smoking.* Direct Oregon Medicaid costs related to smoking are an estimated $287 million per year. This is equivalent to approximately 10 percent of total annual expenditures for Medicaid in Oregon.[4] While overall tobacco use rates in Oregon are below national levels and trending downward, adult Medicaid clients are nearly twice as likely to smoke as Oregon adults in general.[5] Specifically, 37 percent of adult Medicaid clients smoke, compared to 17 percent of Oregon adults. In addition, studies have shown that economic status is the single greatest predictor of tobacco use.[6]
- *Obesity.* Similarly, Medicaid payments for obesity-related care accounted for nearly nine percent of Medicaid costs between 2004 and 2006, a figure that has likely grown as obesity rates have increased.[7]

Figure 2 shows statewide trends in perinatal indicator rates for the Medicaid population. Teen birth rates and low birth rate babies have remained relatively constant over the past 10 years. However, rates of late prenatal care have shown a troubling increase, and the percentage of Medicaid enrollees who smoke during their pregnancy has increased after dropping off in 2007.

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

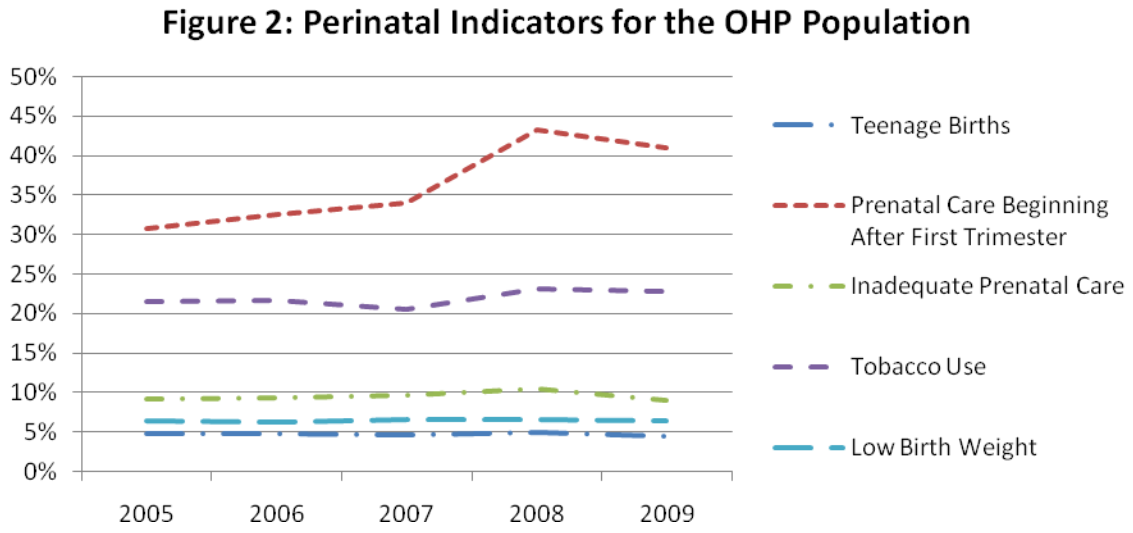

Figure 2: Oregon Vital Statistics Annual Reports 2005-2009

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

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

In many instances, there are large disparities across regions. For example, Region 2's population has a diabetes prevalence rate that exceeds the statewide average by more than 55 percent and exceeds the Region 5 prevalence rate by 96 percent. Similarly, Region 2's population has an asthma prevalence rate that exceeds the statewide average by 14 percent and the Region 6 rate by 25 percent.

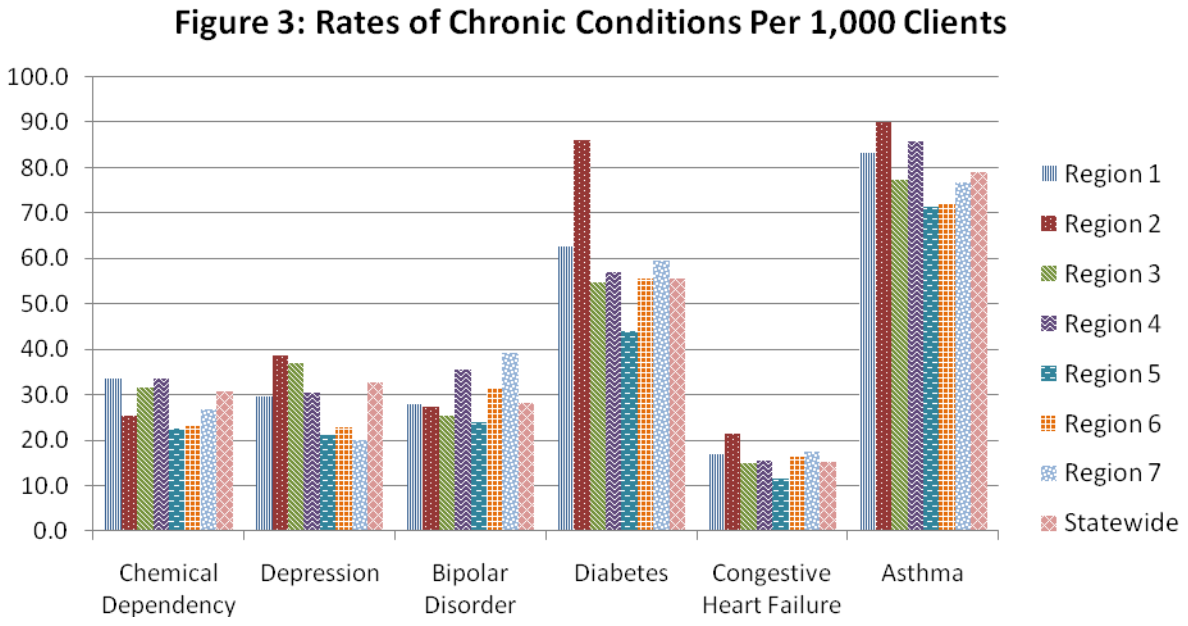

Figure 3: Oregon Health Authority Division of Medical Assistance Programs 8/15/2011.

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

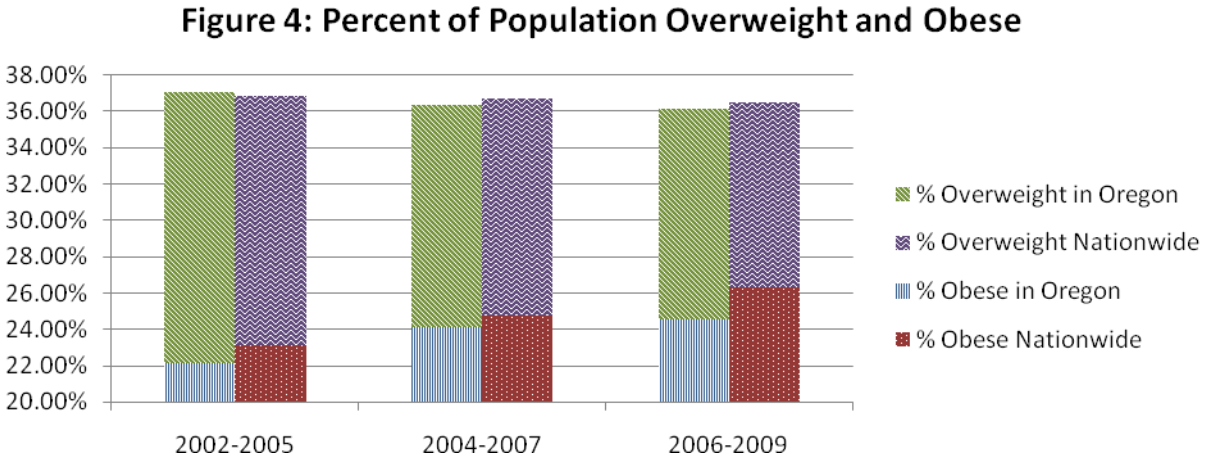

Figure 4: The lower stacks represent the percentage of the population classified as "obese." The total stacks represent the percentage of the population considered "overweight." The data comes from the Behavioral Risk Factor Surveillance System, accessed 12/2011.

Racial and ethnic disparities

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

In its 2011 "State of Equity Report," the Department of Human Services and the Oregon Health Authority identified two disparities in key performance measures across race and ethnicity. For the first measure, the utilization rate of preventative services for children from birth to 10 years of age covered by the Oregon Health Plan, a higher rate is favorable. When comparing across the benchmark of non-Hispanic Whites, Figure 5 shows Native Americans utilizing preventive services at a rate of less than 75 percent of the utilization seen in the White population.

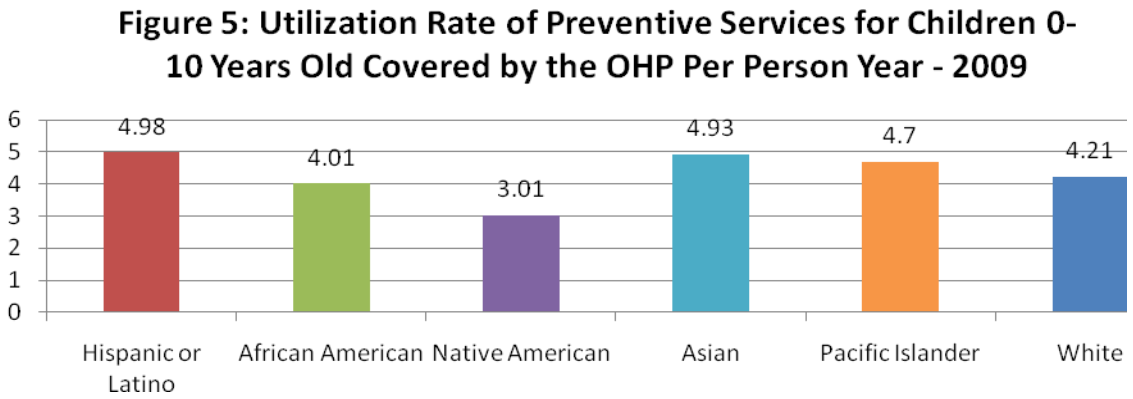

Figure 5: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011. Rates reflect the number of preventive services provided per person year.

In the second measure, the rate of ambulatory care sensitive condition hospitalizations of OHP clients, a lower rate is more favorable. As Figure 6 shows, when comparing rates to the benchmark of non-Hispanic Whites, the Native American population has a higher rate of potentially avoidable hospitalizations. . High rates of hospitalization for ambulatory care sensitive conditions indicate that a condition is not being properly managed. These two disparities together highlight a population in which there is a lack of health care needs being met and indicate a need for outreach and interventions targeted to specific groups.

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

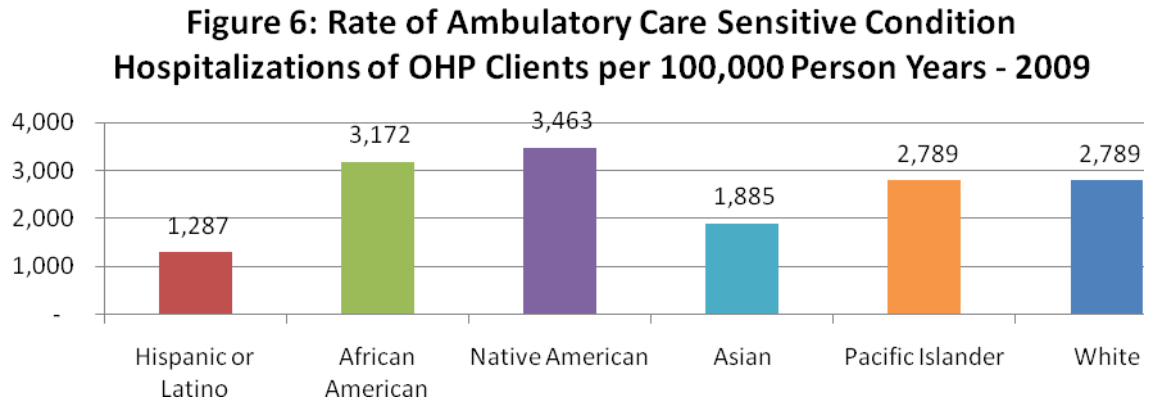

Figure 6: Data extracted from the "State of Equity Report" published by the Department of Human Services and the Oregon Health Authority in June 2011.

<u>Unsustainable cost growth</u>

Without implementing transformation, Health Management Associates estimates that Oregon's Medicaid costs will continue to surge at an average of 10 percent annual growth over the next seven years due to a combination of enrollment growth, increased utilization and inflation in the cost of medical products and services. This greatly exceeds the projected growth rate of General Fund revenue.

3. Opportunities for achieving the Triple Aim: improving health, improving health care and reducing cost

Financial projections for greater system efficiency and value

Current state

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

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

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

Estimates of health transformation savings provided by Health Management Associates

The HMA analysis projects potential savings in six areas. The savings figures in parentheses represent anticipated percentage reductions in expenditures for that component that would take place after implementation is complete and fully scaled, which HMA estimates will take approximately three to five years. *(See Appendix B for more detailed tables)*:

- Improved management of the population (11–15% savings);
- Integration of physical and mental health (10–20% savings);
- Implementation of the Mental Health Preferred Drug List ($0 in the 2011–2013 biennium, $16 million in the 2013–2015 biennium);
- Increased payment recovery efforts (2% savings);
- Patient-centered primary care homes (4–7% savings);
- Administrative savings from MCO reductions (0.2–0.4% savings).

Improve to a well-managed system of care

In 2011, a report by Milliman for the Portland area Oregon Health Leadership Council projected savings for a well-managed Medicaid sub-population (Temporary Assistance for Needy Families, which is largely pregnant women and children) between $118 million and $141 million statewide. According to Milliman, well-managed status reflects attainment of utilization at defined levels equal to optimal benchmarks. Savings reflect the difference between existing service levels and those benchmarks. HMA

projected those findings to the entire Medicaid population by extending Milliman projections to the additional Medicaid groups: the aged, blind and disabled population as well as the expansion population. HMA considers these projections conservative because the complexity and level of chronic disease in these groups is higher and generally yields higher savings.

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

Integration of physical and mental health

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

Implementation of Mental Health Preferred Drug List

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

Increased payment recovery efforts

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

Patient-centered primary care homes

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

Administrative savings from MCO reductions

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

Electronic health records and health information exchange

While not included in the table below, the savings from electronic connectivity and reduction in duplicate testing should be noted. Witter & Associates, LLC, estimate avoided services savings at $16

million a year from the widespread adoption and use of health information exchange (HIE). While implementation of statewide HIE is projected to take four to five years, the resultant savings over time are substantial. These estimates are not net of implementation costs. However, the federal investment in provider incentive payments is providing considerable financial support for these efforts. Additionally, we believe that the savings would be measurable if the costs of implementation could be shared across other payers.

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

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

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

4. Coordinated Care Organization (CCO) certification process

Pending direction and approval by the Legislature during the February 2012 session, the Oregon Health Authority will begin a non-competitive request for applications (RFA) procurement process that specifies the criteria organizations must meet to be certified as a CCO. Prospective CCOs will be asked to submit applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650, including being prepared to enroll all eligible persons within the CCO's proposed service area. Contracts with certified CCOs will be for multi-year periods, with annual renewal based on CCO compliance with DCBS and OHA requirements; this is similar to Medicare Advantage contract renewals. Health insurers certified by the Oregon Department of Consumer and Business Services Insurance Division retain their certification as long as they are in compliance with DCBS and OHA requirements, including financial solvency. For CCOs, OHA will establish a public recertification process in administrative rule.

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

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

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

Evaluation of CCO applications will account for the developmental nature of the CCO system. CCOs, OHA and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by HB 3650. Particular attention will be paid to community involvement in the governance of the CCO, and to the CCO's community needs assessment conducted with its community partners. In all cases, CCOs will be expected to have plans in place for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by HB 3650.

Alternative dispute resolution

HB 3650:

- ***Section 8(4) A health care entity may not unreasonably refuse to contract with an organization seeking to form a coordinated care organization if the participation of the entity is necessary for the organization to qualify as a coordinated care organization.***
- ***Section 8 (5) A health care entity may refuse to contract with a coordinated care organization if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service.***
- ***Section 8 (6) A health care entity that unreasonably refuses to contract with a coordinated care organization may not receive fee-for-service reimbursement from the authority for services that are available through a coordinated care organization either directly or by contract.***
- ***Section 8 (7) The authority shall develop a process for resolving disputes involving an entity's refusal to contract with a coordinated care organization under subsections (4) and (5) of this section. The process must include the use of an independent third party arbitrator. The process must be presented to the Legislative Assembly for approval in accordance with section 13 of this 2011 Act.***

HB 3650 requires the development of a dispute resolution process in establishing CCOs. If a health care entity (HCE) is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization, a process will be available to those parties that includes the use of an independent third-party arbitrator. Because "reasonable cost" is not defined, OHA will clarify in the rule-making process, to the best extent possible, the definition of reasonable cost.

A more complete description of the proposed process is provided in Appendix C. A summary of the primary objectives and components of the process is provided here.

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

This dispute resolution process using an arbitrator applies when (and only when) an HCE is necessary for an organization to qualify as a CCO, but the HCE refuses to contract with the organization. This process is designed to be completed within 60 calendar days. When one party initiates the dispute resolution process, the other party and OHA will receive written notification. The parties will then identify a mutually acceptable arbitrator, who must be familiar with health care issues and HB 3650, and who agrees to follow the dispute resolution process described in Appendix C. In the first 10 days, both parties

must send their most reasonable contract offer to each other and the arbitrator, or an explanation of why no contract is desired; in the next 10 days, the parties can file a written explanation for why the offer or refusal to contract is reasonable or unreasonable. The arbitrator has 15 days to review these materials and issue a decision about whether the HCE refusal to contract is reasonable or unreasonable. Having received the decision, the parties have an additional 10 days to resolve their dispute and agree on a contract. At any point in the process, the parties can agree on terms and enter into a contract, or mutually agree to withdraw from the dispute resolution process.

OHA realizes that occasions may arise when a CCO refuses to contract with an HCE. As part of implementation planning, a dispute resolution process will be developed to evaluate the reasonableness of such a refusal and to facilitate review of the dispute.

5. Coordinated Care Organization (CCO) criteria

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

Governance and organizational relationships

HB 3650:

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

<u>Governing board</u>

CCO organizational structures will vary to meet the needs of the communities they will serve. There is no single governance solution, and there is risk in being too prescriptive beyond the statutory definition of a CCO governing board. Instead, governing board criteria will support a sustainable, successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim. HB3650 requires that CCOs have a governance structure that includes a majority interest consisting of persons that share the financial risk of the organization. In the context of CCO governance, an entity has financial risk when it assumes risk for Medicaid health care expenses or service delivery either through contractual agreements or resulting from the administration of a global

budget. Entities are also considered at financial risk if they have provided funds that have a demonstrated risk of loss.

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

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

Community advisory council (CAC)

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

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

Clinical advisory panel

Potential CCOs will establish an approach to assuring best clinical practices. This approach will be subject to OHA approval, and may include a clinical advisory panel. If the CCO convenes a clinical advisory panel, this group should have representation on the governing board.

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

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

Partnerships

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

needs of CCOs members, and with county health departments and other publicly funded providers for payment for certain point-of-contact services. OHPB directs OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.

Community needs assessment

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

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

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

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

Patient rights and responsibilities, engagement and choice

HB3650:

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

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

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

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

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

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

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

Members enrolled in CCOs should be actively engaged partners in the design and, where applicable, implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices should be reflected in the development of treatment plans; member dignity will be respected. Under this definition, members will

be better positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against under-utilization of services and inappropriate denials of services.

In addition to any other consumer rights and responsibilities established by law, each CCO should demonstrate how it will:

- Use community input and the community needs assessment process to help determine the best methods for patient activation, with the goal of ensuring that patients act as equal partners in their own care;
- Encourage members to be active partners in their health care and, to the greatest extent feasible, develop approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members;
- Engage members in culturally appropriate ways;
- Educate members on how to navigate the coordinated care approach;
- Encourage members to use wellness and prevention resources and to make healthy lifestyle choices;
- Meaningfully engage the community advisory council to monitor patient engagement and activation;
- Provide plain language narrative that informs patients about what they should expect from the CCO with regard to their rights and responsibilities.

None of the patient rights and responsibilities identified above is intended to supplant Medicaid or Medicare law or rule.

Delivery system: access, patient-centered primary care homes, care coordination and provider network requirements
HB3650:

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

- ***Section 4(1)(j) Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.***
- ***Sec 4(1)(k)(G) Members have a choice of providers within the coordinated care organization's network and that providers participating in a coordinated care organization: Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Section 4(1)(n) Each CCO participates in the learning collaborative described in ORS 442.210(3).Section 6(2) Each CCO shall implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology***.
- ***Section 6(3) Standards established by the authority for the utilization of patient centered primary care homes by CCOs may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.***
- ***Sec 20(4) 'Community health worker' means an individual who:***
  - ***c) To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;***
  - ***d) Assists members of the community to improve their health and increases the capacity of the community to meet the healthcare needs of its residents and achieve wellness;***
  - ***e) Provides health education and information that is culturally appropriate to the individuals being served;***

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

<u>Patient-centered primary care homes</u>

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

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

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

<u>Care coordination</u>

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

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

- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care and, in the absence of full health information technology capabilities, how they will implement a standardized approach to patient follow-up;
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services;
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication;
- How they will meet state goals and expectations for coordination of care for individuals receiving Medicaid-funded long-term care services given the exclusion of Medicaid-funded long-term services from CCO global budgets.

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

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

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

- The CCO will ensure a network of providers to serve members' health care and service needs, meet access-to-care standards, and allow for appropriate choice for members as required by HB 3650. The bill also requires that services and supports should be geographically as close to where members reside as possible and, to the extent necessary, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.
- The CCO will build on existing provider networks and transform them into a cohesive network of providers.
- The CCO will work to develop formal relationships with providers, community health partners, and state and local government support services in its service area(s), as required by HB 3650, and how it will participate in the development of coordination agreements among those groups.

<u>Care integration</u>

- *Mental health and chemical dependency treatment:* Outpatient mental health and chemical dependency treatment will be integrated in the person-centered care model and delivered through and coordinated with physical health care services by the CCO. HB 3650 requires OHA to continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a CCO, but no later than July 1, 2013.
- *Oral health:* By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside. Shared financial accountability will encourage aligned financial incentives for cost-effectiveness and to discourage cost shifting.

- *Hospital and specialty services:* Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes and that specify the following: processes for requesting hospital admission or specialty services; and performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care.

Quality assurance and improvement

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

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

Health equity and eliminating health disparities

HB 3650:

- ***Section 2(2). The Oregon Health Authority shall seek input from groups and individuals who are part of underserved communities, including ethnically diverse populations, geographically isolated groups, seniors, people with disabilities and people using mental health services, and shall also seek input from providers, coordinated care organizations and communities, in the development of strategies that promote person centered care and encourage healthy behaviors, healthy lifestyles and prevention and wellness activities and promote the development of patients' skills in self-management and illness management.***
- ***Section 2(3)(b). The authority shall regularly report to the Oregon Health Policy Board, the Governor and the Legislative Assembly on the progress of payment reform and delivery system change including progress toward eliminating health disparities.***
- ***Sec 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in nontraditional settings that are accessible to families, diverse communities and underserved populations.***
- ***Section 4(1)(k)(G). [Providers participating in a Coordinated Care Organization] work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve the health and well-being of members.***
- ***Sec 19(1)(L) The authority shall: Implement policies and programs to expand the skilled, diverse workforce as described in ORS 414.018 (4).***

- ***Sec 30(1)(a) Workforce data collection. Using data collected from all health care professional licensing boards, including but not limited to boards that license or certify chemical dependency and mental health treatment providers and other sources, the Office for Oregon Health Policy and Research shall create and maintain a healthcare workforce database that will provide information upon request to state agencies and to the Legislative Assembly about Oregon's health care workforce, including:***
  (a) Demographics, including race and ethnicity.
  (f) Incentives to attract qualified individuals, especially those from underrepresented minority groups, to health care education.

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

HB 3650 encourages CCOs and their associated providers to work together to develop best practices of culturally appropriate care and service delivery to reduce health disparities and improve health and well-being of members. Through their community needs assessment, CCOs will be expected to identify health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography or other factors in their service areas. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, the OHA Office of Equity and Inclusion should assist in identifying standard components (e.g., workforce) that CCOs should address in the assessment to ensure that all CCOs have a strong and comparable set of baseline data on health disparities.

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

Payment methodologies that support the Triple Aim

HB 3650:

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

To achieve improvements in quality and efficiency in the delivery system, it will be necessary for CCOs to move from a traditionally fee-for-service payment system to alternative methods that link payment to desired outcomes, promote patient-centered care, and compensate providers for prevention, care coordination, and other activities necessary for keeping people healthy. These methods should include transparent measurement of outcomes aligned with the Triple Aim and be guided by the principles outlined by the OHPB Incentives and Outcomes Committee in 2010:

- *Equity* - Payment for health care should provide incentives for delivering evidence-based care (or emerging best practices) to all people.
- *Accountability* - Payment for health care should create incentives for providers and health plans to deliver health care and supportive services necessary to reach Oregon's Triple Aim goals.
- *Simplicity* - Payment for health care should be as simple and standardized as possible to reduce administrative costs, increase clarity and lower the potential for fraud and abuse.
- *Transparency* - Payment for health care should allow consumers, providers and purchasers to understand the incentives created by the payment method, the price of treatment options and the variations in price and quality of care across providers.
- *Affordability* (cost containment) - Payment for health care should create incentives for providers and consumers to work together to control the growth of health care costs by encouraging prevention and wellness, discouraging care that does not improve health, and rewarding efficiency.

In their applications for certification, CCOs will be expected to describe how they will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for their members. Examples include but are not limited to:

- Per-member per-month or other payments designed to support patient-centered primary care homes;
- Bundled payments (case rates, fee-for-service rates with risk sharing, or other) for acute episodes, or for episodes of chronic care defined by a calendar period;
- Incentives for service agreements between specialty and primary care physicians;
- Gain-sharing arrangements with providers, if volume is sufficient;
- Quality bonuses or other payment incentives for performance improvement on Triple Aim-focused quality, efficiency and outcomes metrics; and
- Incentives for the use of evidence-based and emerging best practices and health information technology.

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

Health information technology

HB 3650:

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

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

<u>Electronic health records systems (EHRs)</u>

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

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

<u>Health information exchange (HIE)</u>

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

- **Either** registered with a statewide or local direct-enabled health information service provider (HISP);
    - Direct is a way for one provider to send secure information directly to another provider without using sophisticated information systems. Direct secure messaging will be available to all providers as a statewide service. While EHR vendors will continue to develop products with increasingly advanced direct functionality, using direct secure messaging does not require an EHR system. Registration will ensure the proper identification of participants and secure routing of health care messages, and the email address provided with direct secure

messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time.

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

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

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

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

6. Global budget methodology

HB 3650:

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

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

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

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

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

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

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

CCO Global Budget

Populations included in global budget calculations

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

Service/program inclusion and alignment

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

In considering which Medicaid funding streams should be included in the global budget, the budget will start with the presumption that all Medicaid dollars are in the global budget (with the exception of the services explicitly excluded by HB 3650.) See Appendix F for a list of the services funded by Medicaid funds. Without exception, funding and responsibility for all current services provided by managed physical and mental health organizations as well as non-emergent transportation will be included in each CCO's global budget. The services that are currently capitated under physical and mental health organizations account for approximately 80 percent of Oregon's non-long-term care Medicaid expenditures. Non-emergent transportation represents another 2 percent of expenditures.

Currently, 5 percent of Oregon's non-long-term care Medicaid expenditures are associated with payments for dental care through DCOs. Dental expenditures will be included in global budgets based on individual CCO determination, as HB 3650 allows until July 1, 2014 to incorporate these services.

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

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

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

Global budget development

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

A capitated portion that includes the per-member per-month payments for services currently provided through the OHP physical health plans, mental health organizations and (if included) dental care organizations; and,

An add-on component to the capitated portion for the remaining Medicaid services or programs not currently included in capitation payments.

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

<u>Capitated portion of the global budget methodology</u>

At least initially, the capitated portion of CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011–13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that can be realized under a transformed delivery system tailored to meet the needs of the communities the CCOs serve.
Under this approach, potential CCOs will submit a completed base cost template using internal cost data that is representative of a minimum base population. This will not be a competitive bidding process, but OHA actuaries will review the submission for completeness and soundness in order to establish a base rate. Once a base rate is established, the state actuaries will use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

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

for the CCO capitation rates. If CCOs propose to operate in geographic areas where they have little or no experience, state actuaries will use a population-based risk adjustment methodology based on the currently used Chronic Illness and Disability Payment System (CDPS), to develop the rates in these new areas.

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

Pending direction and approval by the Legislature during the February 2012 session, it is expected that OHA carry out the following process for prospective CCOs (see Section 10 of this document for a timeline):

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

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

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

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

OHA's actuary will assess actuarial soundness at the CCO and region level, and will confer with the CCO regarding any questions or issues that need to be resolved. Additional calculations may be required to ensure that CCO rates in aggregate meet the 2011–2013 legislatively approved budget.

Non-capitated or supplemental portion of the Global Budget Methodology

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

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

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

Blended funding for individuals who are dually eligible for Medicare and Medicaid

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

Quality incentive payments

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

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

7. Accountability

OHA accountability in supporting the success of CCOs

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

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

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

HB 3650:

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

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

CCO accountability

HB 3650:

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

Accountability for each aspect of the Triple Aim — better health, better care and lower costs — is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on outcomes, quality and efficiency measures identified by OHA through a robust public process and in collaboration with stakeholders. CCO accountability metrics will function both to ensure that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650. Further, members and the public deserve to know about the quality and efficiency of their health care so metrics of outcomes, quality and efficiency will be publicly reported. Health care transparency provides consumers with the information necessary to make informed choices and allows the community to monitor the performance of their community CCO.

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

<u>Measurement and reporting requirements</u>

Accountability measures for CCOs will be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. In the first year, accountability will be for reporting only. In future years, CCOs will be accountable for meeting specified performance benchmarks (see accountability standards below). Initially, years will be based on the effective date of each CCO's contract; that is, year one for a CCO that starts operation in July 2012 run through June 2013 and year one for a CCO that is certified in November 2012 will run through October 2013. However, all CCOs must meet performance benchmarks by January 2014. CCOs that begin operation less than a year before that date will have a shorter reporting-only accountability period and CCOs that start on or after January 2014 will have no phase-in period at all.

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

Specific areas of CCO accountability metrics

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

- Core measures will be Triple-Aim oriented measures that gauge CCO performance against key expectations for care coordination, consumer satisfaction, quality and outcomes. They will be uniform across CCOs and will encompass the range of services included in CCO global budgets (e.g., behavioral health, hospital care, women's health, etc.).
- Transformational metrics will assess CCOs' progress toward the broad goals of health systems transformation and will therefore require systems transitions and experimentation in effective use. This subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners.

The initial set of CCO accountability metrics and data sources will be established in consultation with the CMS and the technical advisory group in early 2012, in advance of the request for CCO applications. See Appendix G for examples of potential CCO accountability metrics and an example of how accountability for transformation can be shared across the system.

Accountability standards, monitoring and oversight

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

As with the reporting expectations, accountability standards will be introduced over time. During every phase of reporting:

- Year one — accountability for reporting only, reporting without budgetary or contractual consequences;
- Years two and three — CCOs expected to meet or exceed minimum performance expectations set for core measures and to improve on past performance for transformational measures.

Quality incentive payments may be offered after year one. The board supports Oregon's discussions with CMS to develop an incentive program as early as possible.

OHA, in cooperation with the technical advisory group described above, will use data from CCOs' first reporting periods to establish baselines and to set benchmarks for both minimum and outstanding performance using those baselines. The technical work group will also advise OHA on adopting and retiring measures or on moving "transformational" measures to the core set.

Annual review of CCO accountability metrics

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

Shared accountability for long-term care

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

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

Further, since individuals receiving Medicaid-funded LTC services and supports represent a significant population served by CCOs, CCOs should include these individuals and the LTC delivery system in the community needs assessment processes and policy development structure.

8. Financial reporting requirements to ensure against risk of insolvency

HB 3650:

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

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

Audited statements of financial position and guarantees of ultimate financial risk

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

> "[E]nsure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of $2.5 million of capital and surplus for an insurer to be authorized to transact insurance. This floor increases as the company assumes more insurance risk. Capital and surplus is the amount a company's assets exceed liabilities." "Health Insurance in Oregon," DCBS; January 2009; p8

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

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

Further, to the extent permissible, financial information collected as required by HB 3650 should be transparent and made available online. This kind of transparency will enable the community to evaluate the financial condition of the CCO and increase confidence in the effectiveness of its governance. A high level of transparency also will enable the CCO board to take early corrective actions. It is critical that CCOs provide understandable, comprehensive and reliable information about their financial status and performance.

Financial solvency

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

- *Risk-bearing entity*: As required by HB 3650, the CCO will identify whether the CCO itself or some other entity (such as a state or local government agency, or a reinsurer) will guarantee the CCO's ultimate financial risk, in full or in part. In some cases, CCOs may enter into contracts with hospitals, physician groups, or other providers to share in the financial risk (and rewards) associated with the difference between targeted or projected expenditures and actual expenditures. The extent to which these arrangements reduce the risk borne by the CCO itself will be factored into an actuary's determination of the CCO's reserves.
- *Reinsurance*: Provided through the state or purchased individually by CCOs, reinsurance will act to limit the financial risk of the CCO by capping its risk exposure on either a case-by-case or aggregate basis.
- *Claims reserves*: An adequate amount of liquid assets to satisfy claims liability is required of health plans providing commercial, Medicare and Medicaid coverage in Oregon. Claims reserve requirements for CCOs will be actuarially determined to reflect the CCO's enrollment level and its mix of covered lives based on rate category.
    - *Medical loss ratio*: This is the ratio of expenditures (or claims) incurred for the provision of health care services divided by total health care service revenue. Expenditure incurred for health care services is the amount paid plus the change in the unpaid claim liability. The unpaid claim liability is an estimate for claims already reported but not yet paid and an estimate of the claims for health care services used by a member that have not yet been submitted for payment.
    - *Size of the organization and risk characteristics*: Total number of insured lives and the risk characteristics across all lines of business will be considered ("risk-based capital").
    - *Enrollment level*: The predictability of CCO expenditures and the ability of the CCO to bear risk are reduced at lower enrollment levels. CMS currently requires that Medicare Advantage Plans have a minimum enrollment level of 5,000 beneficiaries. OHPB recommends that CCOs be required to file their actual and projected enrollment levels by rate category.
    - *Organizational liability*: As required by HB 3650, CCOs will be required to file a statement identifying the entity that will be the guarantor of the CCO's ultimate financial risk and any other entities or persons sharing in that risk (in addition to identifying contracting providers bound by risk-sharing agreements with the CCO).
    - *Real property, investments and executive compensation*: As required by HB 3650, each CCO will be required to disclose their real property holdings, their 20 largest investment holdings, and executive compensation. The NAIC form for annual statements includes schedules that provide details on each of these items.
    - *Operating budget*: As described below, OHPB recommends that each CCO be required to describe an annual operating budget including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting any alternative payment methodologies implemented. This operating budget will serve both to indicate the financial soundness of the CCO and to demonstrate that the CCO has developed its budget to reflect the requirements and objectives of health systems transformation.

- *Administrative expenses*: As required by HB 3650, each CCO will be required to outline, by category, administrative expenses relating to provision of services under its CCO contract. The NAIC form for annual statements includes a schedule of expenses by expense category. The expense schedule would show CCO expenses for all of its populations — those incurred under its CCO contract as well as contracts for other populations, including Medicare, PEBB, OEBB and other commercial insurance. Other schedules and note disclosures required by the NAIC form will provide information about expense arrangements with a parent or affiliate organization and detail amounts paid for such service arrangements. A comprehensive understanding of CCO administrative expenses will make possible a more accurate evaluation of the CCO's overall sustainability.

OHA monitoring and oversight

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

<u>Quality, access and financial monitoring</u>

Measures for monitoring and oversight in these areas should be aimed initially at root cause analysis and assisting the CCO in developing improvement strategies. Technical assistance for performance improvement will be the primary strategy in the first year of CCOs' operation, when their accountability will be for reporting only. Informal interim reporting (quarterly or semi-annually) will facilitate timely feedback and allow for mid-course corrections such that CCOs will be prepared to meet specified quality standards in year two, whether those standards are absolute benchmarks or expected improvement on past performance. When the evidence indicates that a CCO is not meeting performance standards, steps taken should be progressive, building on current accountability mechanism for MCOs, and may include:

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

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

If quarterly reports or other evidence suggest that a CCO's financial solvency is in jeopardy, OHA and DCBS will act as necessary to protect the public interest. These measures have two objectives: first, to

restore financial solvency as expeditiously as possible; and second, to identify the causes of the threat to solvency and implement measures to prevent such threats in the future. Actions may include:

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

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

Public disclosure of information

Current DCBS rules require the public disclosure of information pertaining to licensed insurers. As required by HB 3650, OHA will ensure that CCO financial information is transparent and made available online.

CCO licensure

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

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

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

Corporate assets and financial management

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

- Tangible net equity and other assets;
- Risk reserves, current and scheduled, based on enrollment and projected utilization;
- Risk management measures;
- Delegated risk;
- Reinsurance and stop-loss;
- Incurred but not reported (IBNR) tracking;
- Claims payment;
- Participation in the All Payer All Claims reporting program as required by Section 4(k)(L);
- Internal auditing and financial performance monitoring;
- Administrative cost allocation across books of business (including Medicaid, Medicare and commercial).

9. Medical liability

HB 3650:

- ***SECTION 16. Health care cost containment. (1) The Oregon Health Authority shall conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures, while protecting access to health care services for those in need and protecting their access to seek redress through the judicial system for harms caused by medical malpractice. The study and recommendations should address but are not limited to:***
  - ***(a) An analysis of the cost of defensive medicine within the Oregon health care delivery system and its potential budget impact, and containment and savings that would result from recommended changes.***
  - ***(b) Identification of costs within the health care delivery system, including costs to taxpayers and consumers related to care and utilization rates impacted by defensive medical procedures or medical malpractice concerns.***
  - ***(c) An analysis of utilization, testing, services ordered, prescribed or delivered through centers or facilities in which there is a financial interest between the provider requesting a test or service and the entity or individual providing the test or service, including an examination of Stark laws exceptions and exemptions.***
  - ***(d) Establishment of criteria for evaluation and reduced utilization of services and procedures where the health of those served is not negatively impacted or necessarily improved.***
  - ***(e) Identification and analysis of the benefits and impact of caps on medical liability insurance premiums as well as the benefits and potential cost saving from the extension of coverage through the Oregon Tort Claims Act to those who serve or act as agents of the state.***
  - ***(f) A path for a cap on damages for those acting on behalf of the state and serving individuals who receive medical assistance or have medical coverage through other publicly funded programs.***
  - ***(g) An examination of the possible clarifications and limitations on joint and several liability requirements for coordinated care organizations so that these organizations can assume the risk of their actions but are not liable for the actions of others within the coordinated care organization or its contracted services.***
  - ***(h) The effectiveness of binding and nonbinding medical panels in addressing claims of medical malpractice.***

(2) The authority shall coordinate with the Department of Consumer and Business Services and other appropriate agencies, including nongovernmental agencies, in order to collect and analyze the data generated by the study and to make complete recommendations to the Legislative Assembly.

(3) The authority shall secure assistance and input from stakeholder organizations in an effort to secure the best information available relevant to the impacts on administrative costs resulting from litigation, as well as to identify cost containment or cost reduction mechanisms.

(4) The authority shall focus its efforts on the medical malpractice marketplace and coverage throughout Oregon and the impact of implementing medical malpractice liability caps, in order to provide complete information to the Legislative Assembly as it studies the collective elements of health system transformation.

(5) The authority shall present the study and recommendations for addressing health care cost containment and cost reductions to the Legislative Assembly at the same time that the coordinated care organization qualification criteria and global budgeting process are presented to the Legislative Assembly for approval under section 13 of this 2011 Act.

Section 16 of HB 3650 directed the Oregon Health Authority (OHA) to conduct a study and develop recommendations for legislative and administrative remedies that will contain health care costs by reducing costs attributable to defensive medicine and the overutilization of health services and procedures. Specifically, Section 16 directed the OHA to explore the costs, benefits and impacts of defensive medicine and consider several types of medical liability reform options.

To accomplish this work, OHA contracted with consultants with expertise in the areas of medical liability reform and health care data analysis and worked with the Oregon Department of Justice (DOJ) on a legal analysis of related policy. OHA also solicited input from stakeholders regarding medical liability reform options in the Oregon marketplace. Final reports for each of the analyses can be viewed at www.oregon.gov/OHA/OHPR/ by clicking on the "Documents, Reports, Presentations" page.

These analyses do not suggest that there is any single solution that will solve all the issues of the health care system. The medical liability system is a critical aspect of an efficient health care system, but it also has an impact on Oregon's work force as it relates to provider education, retention and recruitment. Further, it strains work force capacity when time is spent providing unnecessary lab or X-ray studies, or hospital stays ordered for defensive medicine purposes.

Ultimately, any reforms chosen need to balance three key factors: reduction of costs, improved patient safety, and equity for those individuals who are injured as a result of medical errors.

Therefore, OHA recommends that the appropriate body or — in the case that no appropriate body is identified, the Oregon Health Policy Board— review these studies in detail, outline advantages and disadvantages as to how options meet the desired policy goals and, as appropriate, draft legislative concepts for the 2013 Legislature. Such suggestions may include:

- Consider the key next steps for an Administrative Compensation System (ACS) in Oregon. This evaluation should include assessing the best design for such a system and include an actuarial evaluation, specifically estimating the premiums paid and the potential number of injured, including a definition of "fault" vs. "no-fault," and setting payment thresholds.
- Evaluate the suggested refinements to Oregon's Joint and Several Liability statutes and assess the feasibility of making those changes in the 2013 legislative session.
- Evaluate the feasibility and affordability of extending the OTCA or another type of liability funding arrangement for Oregon providers.
- Evaluate the viability of pursuing caps on non-economic damages, considering our current partial caps for wrongful death, prenatal and perinatal injury.
- Evaluate how CCOs could partner with hospitals in their community to adopt optimal apology and offer arrangements among their networks, and assess any needed statutory changes or other barriers to implementation.
- Evaluate the use of safe harbors through establishing a standard of care, with consideration of the results of Oregon's AHRQ grant-funded analysis of safe harbor closed-claims analysis.

10. Implementation plan

Transition strategy

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

- *Financial incentives*: Global budget adjustments, annual trend rates, and incentive payments or enhanced federal financial payments, if available, could be structured to support CCOs, providing financial incentives to form the new organization early. This approach provides not only strong incentives and resources for CCOs, but also underscores the urgency and priority of health system transformation.

- *Enrollment incentives*: Building sufficient enrollment to mitigate risk is essential for CCO start-up. New eligibles and those due for annual redetermination should be automatically enrolled in CCOs. This strategy will need to take into account the choice and notification of enrollees, including those eligible for both Medicare and Medicaid.

- *Flexibility incentives*: Efforts to provide flexibility in service delivery and administration should be directed first and foremost to CCOs.

- *Technical assistance and training incentives*: CCOs will benefit from the learning collaborative that OHA will establish, as required by HB 3650, and from state-level work to accumulate evidence about and disseminate information on innovative service delivery practices. If OHA successfully applies for and receives enhanced federal financial contributions for workforce training, then these funds would also be made available to CCOs that invest in developing the alternative workforce identified in HB 3650, including community health workers, peer wellness specialists, and personal health navigators.

Transitional provisions in HB 3650

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

Implementation timeline

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

Rules:

March 2012	OHA will release temporary administrative rules defining CCO criteria and other administrative rule changes as necessary.
June-September 2012	OHA administrative rules process to finalize CCO/MCO changes that include the required Rules Advisory Committee.

CCO applications:

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

Contracts:

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

Implementation:

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

11. Appendices

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

Appendix A: Current managed care plans and service areas

Fully capitated health plans (FCHP) and physician care organizations (PCO)

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

Mental health organizations (MHO) and dental care organizations (DCO)

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

Plan	Organization type	Counties served
Verity Integrated Behavioral Healthcare Systems	MHO	Multnomah
ODS Community Health, Inc.	DCO	Baker, Benton, Clackamas, Clatsop, Columbia, Crook, Deschutes, Hood River, Jackson, Jefferson, Josephine, Lane, Linn, Marion, Malheur, Multnomah, Polk, Tillamook, Wallowa, Wasco, Washington, Yamhill
Pacific Source Community Solutions, Inc.	MHO	Crook, Deschutes, Jefferson, Klamath
Washington County Department of Mental Health	MHO	Washington
Willamette Dental Group	DCO	Benton, Clackamas, Clatsop, Columbia, Deschutes, Douglas, Jackson, Josephine, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Washington, Yamhill

Appendix B: HMA financial projections and savings estimates implementation of "well-managed" by program

Data are by calendar year but were prorated and accumulated into state fiscal years for the summary report.

TANF

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	351,738	$1,312,400,000	$0	$1,312,400,000	$0	$1,312,400,000	$0
2011	398,997	$1,528,000,000	$0	$1,528,000,000	$0	$1,528,000,000	$0
2012	422,055	$1,658,900,000	($12,200,000)	$1,646,700,000	($24,700,000)	$1,634,200,000	($12,500,000)
2013	430,829	$1,738,200,000	($38,900,000)	$1,699,300,000	($51,800,000)	$1,686,400,000	($12,900,000)
2014	435,565	$1,803,600,000	($67,100,000)	$1,736,500,000	($94,000,000)	$1,709,600,000	($26,900,000)
2015	444,300	$1,888,300,000	($140,600,000)	$1,747,700,000	($168,600,000)	$1,719,700,000	($28,000,000)
2016	453,200	$1,977,300,000	($220,700,000)	$1,756,600,000	($235,500,000)	$1,741,800,000	($14,800,000)
2017	462,300	$2,070,300,000	($246,500,000)	$1,823,800,000	($308,100,000)	$1,762,200,000	($61,600,000)
2018	471,500	$2,167,800,000	($258,100,000)	$1,909,700,000	($322,800,000)	$1,845,000,000	($64,700,000)
2019	480,900	$2,270,100,000	($270,300,000)	$1,999,800,000	($338,000,000)	$1,932,100,000	($67,700,000)

Disabled Non-dual

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	49,000	$745,800,000	$0	$745,800,000	$0	$745,800,000	$0
2011	50,300	$800,100,000	$0	$800,100,000	$0	$800,100,000	$0
2012	53,500	$872,300,000	($4,800,000)	$867,500,000	($9,800,000)	$862,500,000	($5,000,000)
2013	55,100	$946,200,000	($15,900,000)	$930,300,000	($21,300,000)	$924,900,000	($5,400,000)
2014	56,700	$1,024,800,000	($28,800,000)	$996,000,000	($40,200,000)	$984,600,000	($11,400,000)
2015	60,700	$1,115,600,000	($62,600,000)	$1,053,000,000	($75,100,000)	$1,040,500,000	($12,500,000)
2016	64,300	$1,214,700,000	($102,200,000)	$1,112,500,000	($108,900,000)	$1,105,800,000	($6,700,000)
2017	68,100	$1,322,500,000	($118,500,000)	$1,204,000,000	($148,300,000)	$1,174,200,000	($29,800,000)
2018	72,100	$1,440,100,000	($129,200,000)	$1,310,900,000	($161,400,000)	$1,278,700,000	($32,200,000)
2019	76,400	$1,568,000,000	($140,700,000)	$1,427,300,000	($175,800,000)	$1,392,200,000	($35,100,000)

Expansion

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	40,572	$219,500,000	$0	$219,500,000	$0	$219,500,000	$0
2011	68,806	$389,400,000	$0	$389,400,000	$0	$389,400,000	$0
2012	58,851	$348,400,000	($2,600,000)	$345,800,000	($5,200,000)	$343,200,000	($2,600,000)
2013	58,550	$362,600,000	($8,100,000)	$354,500,000	($10,800,000)	$351,800,000	($2,700,000)
2014	62,199	$402,900,000	($15,000,000)	$387,900,000	($21,000,000)	$381,900,000	($6,000,000)
2015	198,550	$1,345,300,000	($100,200,000)	$1,245,100,000	($120,100,000)	$1,225,200,000	($19,900,000)
2016	211,050	$1,495,800,000	($167,000,000)	$1,328,800,000	($178,200,000)	$1,317,600,000	($11,200,000)
2017	223,550	$1,657,300,000	($197,300,000)	$1,460,000,000	($246,600,000)	$1,410,700,000	($49,300,000)
2018	236,050	$1,830,500,000	($217,900,000)	$1,612,600,000	($272,600,000)	$1,557,900,000	($54,700,000)
2019	248,550	$2,016,100,000	($240,100,000)	$1,776,000,000	($300,200,000)	$1,715,900,000	($60,100,000)

Dual-eligibles -- Medicaid data

	Enrolled	Projected paid	Low savings	"Well-managed"	High savings	"Well-managed"	Difference
2010	58,100	$168,300,000	$0	$168,300,000	$0	$168,300,000	$0
2011	61,600	$182,300,000	$0	$182,300,000	$0	$182,300,000	$0
2012	65,200	$201,800,000	($1,100,000)	$200,700,000	($2,300,000)	$199,500,000	($1,200,000)
2013	70,300	$227,600,000	($3,800,000)	$223,800,000	($5,100,000)	$222,500,000	($1,300,000)
2014	75,500	$255,700,000	($7,200,000)	$248,500,000	($10,000,000)	$245,700,000	($2,800,000)
2015	79,400	$281,300,000	($15,800,000)	$265,500,000	($18,900,000)	$262,400,000	($3,100,000)
2016	84,200	$314,600,000	($26,500,000)	$288,100,000	($28,200,000)	$286,400,000	($1,700,000)
2017	89,300	$351,900,000	($31,500,000)	$320,400,000	($39,500,000)	$312,400,000	($8,000,000)
2018	94,700	$393,600,000	($35,300,000)	$358,300,000	($44,100,000)	$349,500,000	($8,800,000)
2019	100,400	$440,500,000	($39,500,000)	$401,000,000	($49,400,000)	$391,100,000	($9,900,000)

Appendix C:
Alternative dispute resolution (ADR) process outline

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

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

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

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

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

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

Length of time for the arbitration process: Since Section 8 establishes this arbitration process when an organization is seeking to become qualified as a CCO, a dispute with a necessary HCE should be resolved

promptly. A timeline of 60 calendar days is recommended once an arbitration process is initiated by one of the parties. Extending the time should require the written agreement of both parties.

Process for resolving disputes under Section 8(4) to (7)

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

1. Organization is seeking to become certified as a CCO (Applicant) and:
   a. Applicant asserts that a health care entity (HCE) is necessary for Applicant to qualify as a CCO;
   b. An HCE asserts that its inclusion is necessary for Applicant to be certified as a CCO; or
   c. OHA, in reviewing Applicant information, identifies the HCE as necessary for Applicant to qualify as a CCO.
2. If there is disagreement between an Applicant and HCE regarding whether the HCE is "necessary," the Applicant or HCE can request review from OHA about whether the HCE may be considered "necessary" for an Applicant to qualify as a CCO.
   a. If the specific HCE is deemed by OHA as not "necessary" for Applicant to be certified as a CCO, then this specific process does not apply per Section 8.
   b. The process described below only applies where an HCE is deemed by OHA as "necessary" for the Applicant to be certified as a CCO (or the parties agree that the HCE is "necessary" for an Applicant to qualify as a CCO), in accordance with Section 8.
3. If deemed by OHA as "necessary" or the parties agree that the HCE is "necessary," the HCE and Applicant participate in contract negotiations.
   a. Goal: Applicant and HCE agree on terms and enter into a contract.
4. Request for technical assistance from OHA – voluntary.
   a. Either Applicant or HCE may request OHA technical assistance.
   b. OHA may offer technical assistance. OHA assistance will be confined to clarification of the CCO certification process and criteria, and other program requirements.
5. Before requesting referral to this dispute resolution process, the parties should take the following actions in an attempt to reach a good faith resolution between the Applicant and the HCE:
   a. The Applicant has provided a written offer of terms and conditions to the HCE and the HCE has explained to the Applicant the source of disagreement, if any.
   b. Before referral, the CFO or CEO of each organization has had at least one face-to-face meeting in a good faith effort to resolve the source of disagreement.
   c. Goal: Applicant and HCE agree on terms and enter into a contract.
6. If the Applicant and HCE are unable to reach agreement on contract terms within 10 calendar days of the HCE and Applicant face-to-face meeting in 5(b), either party can notify the other party in writing to initiate referral to an independent third party arbitrator. (At that time, the party initiating the referral will provide a copy of the notification to the OHA.) The arbitrator must:

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

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

1. After notification that arbitration is being initiated, the parties agree upon the arbitrator and complete paperwork required to secure the arbitrator's services – costs for arbitration to be borne by the parties. (Estimated 15 calendar days.)
    a. In consideration of potentially varied financial resources as between the parties that should not pose a barrier to the use of this process, the arbitrator should be permitted to respond to requests to allocate costs among the parties.
    b. Any changes to the time periods described in this process will require the written agreement of both parties.
2. Once referral is completed (step 1), the Applicant and HCE have 10 days to submit to each other and the arbitrator their most reasonable contract offer (10 calendar days) or submit a statement from the HCE that no contract is desired and why this is reasonable.
3. The parties then have 10 days from receipt of the other party's offer, or HCE statement that no contract is desired, to submit to the arbitrator and the other party their advocacy briefs regarding whether the HCE is reasonably or unreasonably refusing to contract with the Applicant. (10 calendar days.)
    a. Legal standards for arbitration:
        i. An HCE may reasonably "refuse to contract with a CCO if the reimbursement established for a service provided by the entity under the contract is below the reasonable cost to the entity for providing the service" – per Section 8(5).
        NOTE: Where federal or state statute or regulation establishes particular reimbursement requirements (e.g., Type A and B hospitals, federally qualified health centers, rural health centers, providers of Indian health services), those laws shall be applied.
        ii. In addition to subparagraph (i), an HCE may reasonably refuse to contract if that refusal is justified in fact or by circumstances, taking into consideration the legislative policies described in HB 3650. Some examples of facts or circumstances pertinent to what is a "reasonable" or "unreasonable" refusal to contract include, but are not limited to:

            1. Whether participation in the CCO contract imposes demands on the HCE that the HCE cannot reasonably meet without significant negative impact on HCE costs, or HCE obligations or structure, in the context of the proposed reimbursement arrangement or other CCO requirements, including, but not limited to, use of electronic health records, service delivery requirements, or quality or performance requirements.
            2. Whether refusal to contract by the HCE impacts access to covered services in the community that should be provided by the CCO. This factor alone should not be used to find a refusal to contract unreasonable, but it is recognized that HCEs and

CCOs should be encouraged to make a good faith effort to work out differences in order to achieve beneficial community objectives and the policy objectives of HB 3650.

3. Whether the HCE has entered into a binding obligation to participate in the network of a different CCO, and that HCE participation significantly reduces HCE capacity to participate in the Applicant's CCO.

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

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

This document reflects the statement of work and certification criteria for Coordinated Care Organizations (CCOs) that will contract with OHA under HB 3650 and has been developed through the work of the Oregon Health Policy Board and its four work groups, a series of eight community meetings around the state, public comment at the monthly Oregon Health Policy Board meetings, and comment from the legislature. **This is a working document and is for discussion purposes only.**

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Governance structure: **Each CCO has a governance structure that includes:** • **A majority interest consisting of the persons that share the financial risk of the organization;** • **The major components of the health care delivery system; and** • **The community at large, to ensure that the organization's decision making is consistent with the values of the members of the community.**	CCO will clearly articulate: • How it will meet governance structure criteria from HB 3650; • How the governing board makeup reflects community needs and supports the goals of health care transformation; • What criteria will are/were used to select for governing members; • How it will assure transparency in governance.	NA
Community advisory council: **Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of the membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met**	• A member of the CAC must sit on the governing board to ensure accountability for the governing board's consideration of CAC policy recommendations.	
Dental care organizations: **On or before 7/1/14, each CCO will have a formal contractual relationship with any DCO in its service area.**	• CCO adheres to HB 3650 requirements regarding DCOs.	• CCO enters into shared financial accountability arrangement with DCOs before 2014, to encourage aligned financial incentives for cost-effectiveness and discourage cost shifting.

Appendix D: Draft matrix of suggested CCO criteria
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Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Partnerships: **CCOs shall have agreements in place with publicly funded providers to allow payment for point-of-contact services including immunizations, sexually transmitted diseases and other communicable diseases, family planning and HIV/AIDS prevention services. Additionally, a CCO is required to have a written agreement with the local mental health authority in the area served by the coordinated care organization, unless cause can be shown why such an agreement is not feasible under criteria established by the Oregon Health Authority.**	• OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.	
Person-centered care: **Each member receives integrated person-centered care and services designed to provide choice, independence and dignity.**	• CCO describes how it will use PCPCH capacity to deliver person-centered care per HB 3650 and ensure members are fully informed partners in transitioning to this model of care.	
Safeguards for members: **OHA shall adopt rules for member safeguards including: protections against underutilization of services and inappropriate denials; access to qualified advocates; education and engagement to help members be active partners in their own care.**	• CCO adheres to HB 3650 requirements regarding member safeguards, including access to qualified peer wellness specialists where appropriate, personal health navigators, and qualified community health workers, and to applicable Medicare and Medicaid regulations not waived. • CCOs will describe planned or established mechanisms for a complaint/grievance and appeals resolution process, including how that process will be for communicated to members and providers.	

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Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Patient engagement: **CCO operates in a manner that encourages patient engagement, activation and accountability for the member's own health.**	• CCO actively engages members in the design and, where applicable, implementation of their treatment and care plans • CCO ensures that member choices are reflected in the development of treatment plans and member dignity is respected.	• CCO uses community input and the community needs assessment process to help determine the best methods for patient activation • CCO develops approaches to patient engagement and responsibility that account for the social determinants of health relevant to their members • CCO meaningfully engages the community advisory council to monitor patient engagement and activation.
Member access and provider responsibilities: **Members have *access* to a choice of providers within the CCO's network and providers in the network:** • **Work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members;** • **Are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history;** • **Emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision making and communication;** • **Are permitted to participate in networks of multiple CCOs;** • **Include providers of specialty care;** • **Are selected by CCOs using universal**	CCO describes: • How it will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including long-term care services and crisis management services; • How it will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of both parties in the process of communication; • How members will be informed about access to non-traditional providers, if available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and community health workers.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
application and credentialing procedures, objective quality information; are removed if providers fail to meet objective quality standards; • **Work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members.**		
<u>Member and care team</u>: **Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings.**	• CCO demonstrates how it will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and use a standardized patient follow-up approach.	
<u>Holistic care through primary care homes</u>: **Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible.**	• CCO adheres to HB 3650 requirements regarding individualized care plans, particularly for members with intensive care coordination needs. • Care plans reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.	
<u>Transitional care</u>: **Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.**	• CCO demonstrates how it will incent and monitor improved transitions in care so that members receive comprehensive transitional care, as required by HB 3650, and members' experience of care and outcomes are improved. Coordinated care, particularly for transitions between hospitals and long-term care, is key to delivery system transformation. • CCOs should demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care and establish service agreements that include the role of patient-centered primary care homes.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Navigating the system: **Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, community health workers and personal health navigators who meet competency standards established by the Oregon Health Authority.**	• CCO demonstrates how members will be informed about access to non-traditional providers, if available through the CCO, including personal health navigators, peer wellness specialists where appropriate, and community health workers.	
Accessibility: **Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.**	• CCO adheres to HB 3650 requirements for access to services and supports.	
High need members: **Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency; CCO involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions.**	• CCO uses individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.	
Learning collaborative: **Each CCO participates in the learning collaborative described in ORS 442.210.**	• CCO adheres to HB 3650 requirements for participation in learning collaborative.	
Patient-centered primary care homes: **Each CCO shall implement, to the maximum extent feasible, patient-centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse**	• CCO adheres to HB 3650 requirements for patient-centered primary care homes. • CCO demonstrates how the patient-centered primary care home delivery system elements will ensure that members receive integrated, person-centered care and	• All members enrolled in a PCPCH; member experience of care exceeds benchmarks; PCPCH's in advanced tiers.

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology.	services, as described in the bill, and that members are fully informed partners in transitioning to this model of care.	
Health equity: **Health care services focus on improving health equity and reducing health disparities.** Ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors.	• CCO identifies health disparities associated with race, ethnicity, language, health literacy, age, disability, gender, sexual orientation, geography, or other factors through community needs assessment. • CCO collects or maintains race, ethnicity and primary language for all members on an ongoing basis in accordance with standards jointly established by OHA and Oregon Department of Human Services.	
Alternative payment methodologies: **OHA encourages CCOs to use alternative payment methodologies that:** • **Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;** • **Hold organizations and providers responsible for the efficient delivery of quality care;** • **Reward good performance;** • **Limit increases in medical costs;** • **Use payment structures that create incentives to promote prevention, provide person-centered care, and reward comprehensive care coordination.**	• CCO describes how it will use alternative payment methods alone or in combination with delivery system changes to achieve better care, controlled costs and better health for members.	

Appendix D: Draft matrix of suggested CCO criteria
Based on OHPB action plan, OHPB and work group discussions, and public input

Criteria from *HB 3650*	OHPB baseline expectations	OHPB transformational expectations
Health information technology: **Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable.**	• CCO documents level of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and develops a HIT improvement plan for meeting transformation expectations. • CCO participates in a health information organization (HIO) or is registered with a statewide or local direct-enabled health information service provider.	• CCO providers have EHR/HIE capacity to send and receive patient information in real time, and CCOs have the analytic capacity to assess patient outcomes of care coordination.
Outcome and quality measures: **Each CCO reports on outcome and quality measures identified by the Oregon Health Authority under Section 10 and participates in the All Payer All Claims data reporting system.**	• CCO reports and demonstrates an acceptable level of performance with respect to OHA-identified metrics. • CCO submits APAC data in a timely manner according to program specifications.	• CCO demonstrates exceptional performance with respect to identified metrics.
Transparency: **CCO is transparent in reporting progress and outcomes.**	• CCO will clearly articulate how it will assure transparency in governance. • Financial, outcomes, quality and efficiency metrics will be transparent and publicly reported and available on the internet for each CCO.	
Best practices: **Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks.**	• CCO describes capacity and plans for ensuring best practices in areas identified by HB 3650. • CCO establishes a clinical advisory panel (CAP) or uses other means to ensure clinical best practices. The CAP, if one is formed, should be represented on the CCO governing board, similar to the CAC. • CCO describes plans for: an internal quality improvement committee that develops and operates under an annual quality strategy and work plan with feedback loops; and an internal utilization review oversight committee that monitors utilization against practice guidelines and treatment planning protocols/policies.	

Appendix E: Overview of CCO eligible populations

Oregon Medicaid caseload for inclusion in Coordinated Care Organization (CCO) global budgets (includes managed care and fee-for-service)

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

* FCHP - Fully capitated health plan
PCO - Physician care organization

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

Staff reference:
09-11 Dec Rebal; includes FFS and managed care.

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

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

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

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

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

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

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

Medicaid program/services	Description	Current intermediate entity, if any (e.g., counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	% of Non-LTC Medicaid Spend
Aging and People with Disabilities	**Descriptions**			
Payment of Medicare premiums for dual-eligibles	Medicare premium payments for dual-eligibles paid by Medicaid	N/A	Y	4%
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Applicable deductibles, coinsurance and copayment amounts for dually eligible enrollees.	N/A		<1%
OHP Post-Hospital Extended Care	Provides a stay of up to 20 days in a nursing facility to allow for discharge from a hospital to a nursing facility	FFS Only	Y	<1%
Public Health	**Descriptions**			
School-Based Health Center services	Comprehensive primary care clinics that provide physical, mental and preventive health services to school-aged children in a school-based setting.	Local public health authority (LPHA)		1%
Babies First!	A Medicaid-funded nurse home visiting program for families with babies and young children up to 5, with significant health and social risks. Provides health assessments, aligns community resources, strengthens parenting skills, and improves infant health outcomes.	Local health departments		<1%
Maternity Case Management	An education and support program for pregnant women on Medicaid with social or health concerns during pregnancy to improve health outcomes.	Local health departments (DMAP provides reimbursement for MCM services to a broader community of prenatal care providers not under the public health program)		<1%

Appendix G: Principles, domains and example CCO accountability metrics

OHPB Stakeholder Work Group on Outcomes, Quality and Efficiency Metrics

Potential CCO performance measures

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

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

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

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

Domains of measurement

OHA should assess CCO performance in these domains:

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

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

Potential CCO performance measures

Examples only

Measure	Data Type	Other initiatives that use the measure
Rate of tobacco use among CCO enrollees	Survey or medical record	7
Obesity rate among CCO enrollees	Survey or medical record	
Low birth weight	Vital statistics /medical record	2
Well child visits	Claims/encounter data	2, 5, 6
Dental visits (% of members with any visit in past year)	Claims/encounter data	6, 7
Depression screening	Medical record	1, 3, 4, 5
Initiation and engagement in drug, alcohol, and mental health treatment	Claims/encounter data	3, 5, 6
Penetration rate for mental health and chemical dependence treatment	Survey and administrative data	
Cholesterol control for patients with diabetes	Medical record	5
Glucose control for diabetics	Medical record	4
Cancer screening (1 of: cervical, breast or colorectal)	Claims/encounter data	1, 2, 4, 5, 6
Effective contraceptive use and unintended pregnancy	Survey	
Chlamydia screening	Claims/encounter data	1, 2, 5, 6
Fall risk screening (older adults)	Claims/encounter data	4, 6
Service engagement (% members who received no health services at all in x period)	Claims/encounter and administrative data	
Member or patient experience with: · Getting needed care and getting care quickly · Shared decision making and participation in care planning · Care coordination · Chronic disease self-management support · Primary provider or provider team · Overall experience of care	Survey	1, 2, 4, 5, 6
Primary care-sensitive hospital admissions (AHRQ PQIs)	Claims/encounter data	1, 4
ED visits by primary diagnosis (e.g. mental health, substance abuse, dental, other)	Claims/encounter data	
Hospital acquired infection rates	CDC reporting system	
Medication management (e.g., % discharges where medications were reconciled within 7 days)		4, 6
Follow-up after hospitalization (visit within 7 days of discharge for physical or mental health diagnosis)	Claims/encounter data	1, 2, 6
Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)	Claims/encounter data	1, 4, 6
End of life care preferences (e.g. % dual eligibles or age-specified members who have a POLST form on file)	Administrative data	
Health/functional status improvement	Survey	4

1 – Medicaid Adult Core Measures
2 – CHIPRA Core Measures
3 – Medicaid Health Home Core Measures
4 – Medicare ACO Quality Measures
5 – Oregon PCPCH
6 - HEDIS
7 – National Quality Strategy

Accountability by level

Illustrative examples for discussion purposes only

Example domain: Care coordination

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

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