

# Report to the Centers for Medicare & Medicaid Services

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

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Submitted by the Oregon  
Department of Human  
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Study Group



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

Staff Contributors:

Oregon Health Authority: Jeffrey Scroggin (OHA Lead)

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

Max Brown, Selina Hickman, Chelas Kronenberg, Naomi Sacks

Daniel Amos, Jeannette Hulse, Ann McQueen, Chris Sanchez

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

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

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

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

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

## Executive Summary

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

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

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

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

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

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

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

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

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

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

## Introduction

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

Oregon has agreed to conduct an exploratory stakeholder process that would result in a report to CMS regarding the integration of DHS Medicaid-funded long term care for seniors or people with disabilities into CCO global budgets. The report will identify opportunities, barriers, and strategies for integrating long term care, and address issues of scope, process and timeline for integration. The report will be submitted to CMS no later than December 31, 2013.<sup>3</sup>

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

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

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

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

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

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

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

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

<sup>5</sup> A roster of the Study Group is provided in Appendix I.

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

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

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

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

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

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

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

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

Second, Oregon has achieved the following:

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

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

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

## Potential Opportunities and Barriers to Integration

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

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

### Consumer Outcomes and Empowerment

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

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

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

### **Capacity and Access**

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

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

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

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

### **Coordination and Communication**

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

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

## **Prevention**

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

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

## **Financing and Shared Savings**

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

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

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

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

## Background Research into Integration Models

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

### Oregon Programs, Pilots and Proposals of Integrated and Coordinated Care

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

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

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<sup>11</sup> “Providence ElderPlace Portland,”

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

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

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

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

## National and State Data

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

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<sup>13</sup> “CareOregon/APD Long Term Care Pilot,”

<http://www.oregon.gov/dhs/cms/Meeting%20files/CCO%20Subcommittee%20LTC%20presentation%20June%2019%202013x.pdf>, accessed on October 21, 2013.

<sup>14</sup> “Neighborhood Housing and Care Project,”

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

<sup>15</sup> “Housing with Services Initiative: Project Update,”

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

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

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

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

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

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

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

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

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

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

## State Integration Models

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

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

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

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

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

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

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

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<sup>21</sup> A. Lind, S. Gore, and S. Somers. *Profiles of State Innovation: Roadmap for Rebalancing Long Term Supports and Services*. Center for Health Care Strategies, November 2010. Available at: [http://www.chcs.org/publications3960/publications\\_show.htm?doc\\_id=1261188](http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261188)

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

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

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

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

## Strategies and Outcomes: Working through Straw Models

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

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

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

## The Oregon Model Framework for Integration and Coordination

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

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

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

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

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

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

### **Care Team/Care Plan and Coordination across Providers**

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

## Exhibit 1: Domains in Oregon’s Integration Framework

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

## **Financing and Contracting**

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

## **Performance, Quality Measurement, and Monitoring**

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

## **Data and Information Sharing**

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

## **Public and Stakeholder Engagement**

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

## **Consumer Engagement**

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

## **Medicare**

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

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

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

## Timeline

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

Exhibit 2: Timeline for Integration Activities

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

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

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

## Shared Accountability

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

Major accomplishments of the Shared Accountability Sub-Committee include:

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

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<sup>22</sup> National Quality Forum Measures Application Partnership. *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population*. June 2012. Available at: [http://www.qualityforum.org/Publications/2012/06/Measuring\\_Healthcare\\_Quality\\_for\\_the\\_Dual\\_Eligible\\_Beneficiary\\_Population.aspx](http://www.qualityforum.org/Publications/2012/06/Measuring_Healthcare_Quality_for_the_Dual_Eligible_Beneficiary_Population.aspx) and National Committee for Quality Assurance. *Integrated Care for People with Medicare and Medicaid: A Roadmap for Quality*. March 2013. Available at: [http://thescanfoundation.org/sites/thescanfoundation.org/files/ncqa-integrated\\_care\\_for\\_people\\_medicare\\_medicaid-3-6-13.pdf](http://thescanfoundation.org/sites/thescanfoundation.org/files/ncqa-integrated_care_for_people_medicare_medicaid-3-6-13.pdf)

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

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

## Conclusion

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

## Appendix I: Study Group Roster

### Study Group Members:

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

Liz Baxter, MPH, We Can Do Better

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

Carol Burgdorf-Lackes, FamilyCare CCO

Jim Carlson, Oregon Health Care Association

Jerry Cohen, AARP Oregon

Terry Coplin, Trillium Community Health Plan

Stephanie Dockweiler, Malheur County Health Department

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

Ellen Garcia, Providence ElderPlace Portland

Mary Guillen, Medical Interpreter

Ruth Gulyas, LeadingAge Oregon

Tim Malone, LCSW, Deschutes County Behavioral Health

Ruth McEwen, Oregon Disabilities Commission

Wayne Miya, Our House of Portland

Meghan Moyer, Service Employee International Union, Local 503

Margaret Rowland, MD, CareOregon

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

Tina Treasure, State Independent Living Council

Michael Volpe, Intercommunity Health Network CCO Consumer Advisory Committee

**Staff:**

Center for Health Care Strategies:

Alice Lind, Facilitator

Brianna Ensslin

Oregon Health Authority and Department of Human Services:

Jeff Scroggin, OHA Lead

Bob Weir, DHS Lead

Max Brown

Selina Hickman

Chelas Kronenberg

Naomi Sacks

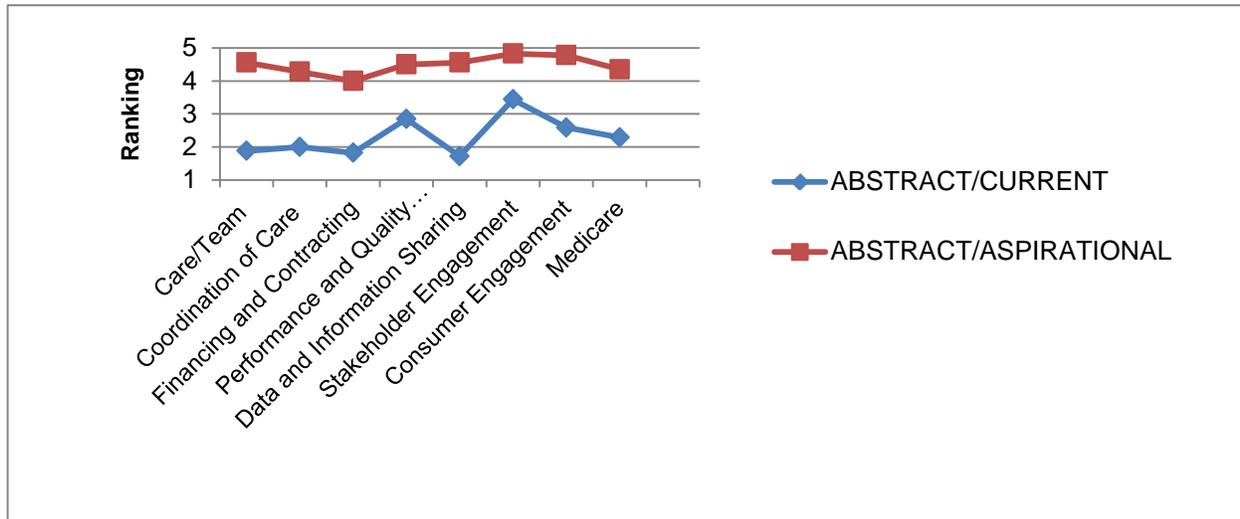
Daniel Amos

Jeannette Hulse

Ann McQueen

Chris Sanchez

## Appendix II: Aspiration Rankings of Oregon Straw Model



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

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

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

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

For more information on the Study Group please visit:

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

### Care Team/Care Plan and Coordination across Providers

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

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

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

## Financing/Contracting

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

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

### **Performance, Quality Measurement, and Monitoring**

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

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

### Data and Information Sharing

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

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

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

### **Public and Stakeholder Engagement**

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

### **Consumer Engagement**

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

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

## Medicare

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

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

## Appendix IV: Shared Accountability Sub-Committee Report

### Sub-Committee Formation, Composition, and Goals

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

The Sub-Committee adopted three goals:

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

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

## Previous Work on Shared Accountability

The Sub-Committee started with agreement to build off of previous shared accountability work in Oregon. This included a Budget Note Workgroup report,<sup>23</sup> a strategic framework for Coordination and Alignment between Coordinated Care Organizations and Long Term Care<sup>24</sup> developed as part of a Duals Demonstration grant application and a subsequent internal workgroup developing draft materials on shared accountability. In addition, the group gained an appreciation for earlier work performed and determined their role was to build upon and strengthen earlier developed concepts, including contracts requiring an MOU between LTSS offices and CCOs and the MOUs themselves.

## Key Sub-Committee Findings and Discussion

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

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

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

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

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

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

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

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

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

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

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

<sup>28</sup> Centers for Disease Control and Prevention. *The State of Aging and Health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2013. Available at [http://www.cdc.gov/features/agingandhealth/state\\_of\\_aging\\_and\\_health\\_in\\_america\\_2013.pdf](http://www.cdc.gov/features/agingandhealth/state_of_aging_and_health_in_america_2013.pdf), accessed October 23, 2013.

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

<sup>30</sup> A. Lind. "Performance Measures and Metrics: Oregon Subgroup on Shared Accountability."

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

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

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

### **Next Steps**

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

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

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

## Appendix V: Performance Measures Selection Criteria for Shared Accountability Metrics

Overall guiding principles for measure selection are:

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

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

## Appendix VI: Public Comments

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

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

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