

# Oregon Health Policy Board

## AGENDA

September 13, 2011

Market Square Building

1515 SW 5th Avenue, 9th floor

8:00 am to 12:30 pm

Live web streamed at: [OHPB Live Web Streaming](#)

	Time	Item	Presenter	Action Item
1	8:00	Welcome, call to order and roll call Consent agenda: 08/09/11 minutes	Chair	X
2	8:05	Director's Report	Bruce Goldberg	
3	8:15	<ul style="list-style-type: none"> <li>Medical Assistance Program (MAP) Update</li> <li>PEBB/OEBB Update</li> </ul>	Judy Mohr Peterson, by phone Joan Kapowich	
4	8:30	Mental Health Services update	Richard Harris OHA Addictions and Mental Health	
5	8:50	Health Leadership Council (HLC) update	Greg Van Pelt Providence Health & Services	
	9:20	Break		
6	9:30	Work Group Feedback: <ul style="list-style-type: none"> <li>Coordinated Care Organization Criteria</li> <li>Global Budget Methodology</li> <li>Outcomes, Quality and Efficiency Metrics</li> <li>Integration of care for people dually eligible for Medicare and Medicaid</li> </ul>	Board Members Tina Edlund	
7	11:00	Oregon Health Policy Board Product to the Legislature.	Diana Bianco, Facilitator	
8	12:00	Public Testimony	Chair	
9	12:30	Adjourn		

### Upcoming

October 11, 2011

Market Square Building

1:00 pm to 4:30 pm



# Oregon Health Policy Board

## DRAFT Minutes

August 9, 2011

1:00 – 4:30pm

Market Square Building  
1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor  
Portland, OR 97201

Item
<p><b>Welcome and Call To Order</b> Vice Chair Lillian Shirley called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present except for Chair Eric Parsons. Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p>
<p><b>Consent Agenda:</b> Minutes from the July 12, 2011 meeting were unanimously approved.</p>
<p><b>Director's Report – Dr. Bruce Goldberg</b> Dr. Goldberg spoke about implementing rate reductions among Oregon Health Plan providers. <i>This report can be found <a href="#">here</a>, starting on page 5.</i></p>
<p><b>Medicaid Update – Jeanny Phillips</b> Jeanny presented cost and enrollment data, which can be found <a href="#">here</a>.</p>
<p><b>PEBB/OEBB Update – Joan Kapowich</b> Joan presented data on PEBB/OEBB costs and conditions. This presentation can be found <a href="#">here</a>.</p>
<p><b>Update: Oregon Health Insurance Exchange (ORHIX) – Rocky King</b></p> <ul style="list-style-type: none"><li>➤ The ORHIX Board will be announced within the next few weeks.</li><li>➤ The business plan for the Exchange will be presented to the Legislature in February.</li><li>➤ The Exchange will become a public corporation on September 1, 2011.</li></ul>
<p><b>Update: Workforce Committee – Lisa Angus</b> Lisa presented information on the tasks that have been assigned to the Workforce Committee, along with the updated proposed charter, which can be found</p>
<p><b>Update: SB 204: Uniform Price Methodology and HB 3650: Medical Liability – Tina Edlund</b> Tina provided an update on the work being done to fulfill the requirements of the two bills. In both cases, RFPs will be issued within the month to engage expert technical assistance in these areas.</p>
<p><b>HB 3650 Health System Transformation Workgroup Membership, Charters, Schedule and Process – Tina Edlund and Bruce Goldberg</b></p> <ul style="list-style-type: none"><li>➤ The workgroups will meet, bring their recommendations to the Board, and then take the Board's comments back to the workgroup. Because these groups are fairly large, they'll use the same small breakout group process that the Health System Transformation Team (HSTT) used.</li><li>➤ The Board commented that in the HSTT meetings, there wasn't time to discuss the reports from the small breakout groups and that the workgroup meetings should be structured to provide that time.</li></ul> <p>The work group charters can be found <a href="#">here</a>, beginning on page 15. <b>The charters for the workgroups were unanimously approved, pending the requested changes.</b></p>
<p><b>Public Testimony</b> Jennifer Valley – Stoney Girl Gardens Foundation Ms. Valley gave the Board an update on her work with medical marijuana. Her group has been working to ensure safe access to medical marijuana throughout the state. Private patient exchange clubs are being started, where patients will have access to medical marijuana in a controlled, compliant environment.</p>
<p><b>Adjourn</b> 3:57 p.m.</p>

**Next meeting:**

**September 13, 2011**

**8:30 am - noon**

**Market Square Building**

**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**

**Portland, OR 97201**

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**Monthly Report to  
Oregon Health Policy Board  
September 13, 2011**

*Bruce Goldberg, M.D.*

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**PROGRAM AND KEY ISSUE UPDATES**

**Healthy Kids Program**

- Through July 2011, **96,432** more children have been enrolled into Healthy Kids for a total child enrollment of **366,505**.
- **5,419** of these children are now enrolled in Healthy KidsConnect.
- This is 120% of our goal of 80,000 more children and a 36% increase in enrollment since June 2009 (baseline).
- *See the chart below for a more detailed look at Healthy Kids enrollment.*

**OHP Standard**

- The 2011/2013 biennial goal is to have an average monthly enrollment of 60,000 individuals enrolled in OHP Standard. This goal has been carried over from the 2009/2011 biennium.
- As of July 15, 2011, enrollment in OHP Standard is now **69,169**.
- There have now been nineteen random drawings to date. The last drawing was on August 3, 2011 for 2,500 names. The next drawing will occur on September 7, 2011 for 2,500 names.

**Donald Berwick, Administrator of the Centers for Medicare & Medicaid Services**

The Governor, Mike Bonetto and I met with Dr. Berwick in August to brief him on our transformation plans. The meeting went well. He remains supportive of the direction we are moving.

**September Legislative Days**

The Oregon Legislature's interim committees will be meeting between September 21st and 23rd. The Senate and House health care committees will be holding a joint committee hearing on September 22nd from 8 to 11:00 a.m. Included on the agenda will be an update on transformation and the health insurance exchange. Senate confirmation hearings will also be held that week for the Governor's appointees to the Health Insurance Exchange Board of Directors. The interim committees will meet two more times before the 2012 legislative session, in November and January.

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### **Transformation Planning with CMS**

We are holding monthly conference calls with national staff at the Centers for Medicare-Medicaid Services to keep them informed of the health system transformation we are developing. Goals are to be sure they are aware of plans so that we remain aligned and can quickly move to federal approval following sign off from Oregon's Legislature.

### **Upcoming**

**Next OHPB meeting:**

**October 11, 2011**

**1:00 PM to 4:30 PM**

**Market Square Building**

	OHP Net Enrollment	HKC Net Enrollment	Total Net Enrollment	Increase Over Baseline	Monthly net enrollment change	% of Goal Achieved
9-Jul	271,493	0	271,493	3,648	3,648	5%
9-Aug	276,712	0	276,712	8,867	5,219	11%
9-Sep	281,374	0	281,374	13,529	4,662	17%
9-Oct	289,015	0	289,015	21,170	7,641	26%
9-Nov	294,459	0	294,459	26,614	5,444	33%
9-Dec	298,600	0	298,600	30,755	4,141	38%
10-Jan	303,026	0	303,026	35,181	4,426	44%
10-Feb	305,785	205	305,990	38,145	2,964	48%
10-Mar	309,047	549	309,596	41,751	3,606	52%
10-Apr	312,191	923	313,114	45,269	3,518	57%
10-May	314,933	1,133	316,066	48,221	2,952	60%
10-Jun	316,891	1,338	318,229	50,384	2,163	63%
10-Jul	319,878	1,662	321,540	53,695	3,311	67%
10-Aug	322,694	1,948	324,642	56,797	3,102	71%
10-Sep	326,545	2,335	328,880	61,035	4,238	76%
10-Oct	331,837	2,700	334,537	66,692	5,657	83%
10-Nov	334,120	3,046	337,166	69,321	2,629	87%
10-Dec	337,498	3,441	340,939	73,094	3,773	91%
11-Jan	342,272	3,712	345,984	78,139	5,045	98%
11-Feb	348,660	4,081	352,741	84,896	6,757	106%
11-Mar	349,424	4,372	353,796	85,867	971	107%
11-Apr	353,526	4,732	358,258	90,329	4,462	113%
11-May	354,070	4,970	359,040	91,111	782	114%
11-June	356,645	5,196	361,841	93,892	2,781	117%
11-July	<b>358,990</b>	<b>5,419</b>	<b>364,409</b>	<b>96,432</b>	<b>2,540</b>	<b>121%</b>

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OFFICE OF THE DIRECTOR

John A. Kitzhaber, MD, Governor

Oregon  
Health  
Authority

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[www.oregon.gov/oha](http://www.oregon.gov/oha)

August 6, 2011

Dear Hospital Partners:

I am writing to urge you to actively support the March of Dimes "*Healthy Babies Are Worth The Wait*" initiative in your organization and in your community. This campaign to put a "hard stop" on elective non-medically necessary inductions and C-sections before 39 weeks gestation, is exactly the kind of community based initiative that is critical to the future of healthcare in Oregon.

This effort has all the elements of creating our healthy future together.

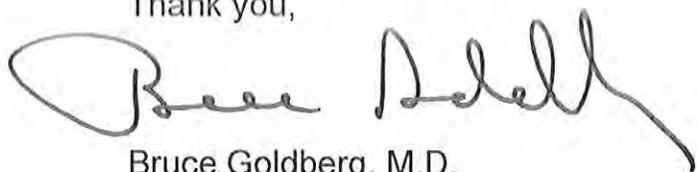
- ✓ It is focused on making evidenced- based care a community wide standard.
- ✓ It has strong support from a community organization committed to launching a broad public education campaign to raise awareness and support.
- ✓ It has strong support from Oregon's health leaders and experts.
- ✓ It will significantly impact cost at a time when funding for even *necessary* care is increasingly constrained.
- ✓ And, most importantly, it removes a cause of harm to the next generation of Oregonians and helps us build the healthier future we all want for our children.

March of Dimes Greater Oregon Chapter, with support from the Oregon Health Leadership Council, has issued a "community challenge" across Oregon to providers to commit to making a "hard stop" on all elective non medically necessary deliveries prior to 39 weeks. This effort will be supported by hospital specific reports to track changes over time.

It is my hope that every community in Oregon will respond to this challenge and that a year from now we will all be able to celebrate that we have made a significant difference for the health of our entire state.

You are being contacted as someone who can make a difference. Please do everything you can to make sure this campaign is a success for Oregon.

Thank you,

A handwritten signature in black ink, appearing to read "Bruce Goldberg". The signature is fluid and cursive, with a large initial "B" and a long, sweeping tail.

Bruce Goldberg, M.D.  
Director

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# Addictions and Mental Health Division (AMH)

AMH System Change Work  
Presentation for the Oregon Health Policy Board  
*Richard Harris, Director*

*September 13, 2011*



# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## MISSION & GOALS

- The mission of AMH is to assist Oregonians to achieve optimum physical, mental and social well being by providing access to health, mental health and addiction services and supports, to meet the needs of adults and children to live, be educated, work and participate in their communities.
- AMH's goals are to:
  - Improve the lifelong health of all Oregonians;
  - Improve the quality of life for the people served;
  - Increase the availability, utilization and quality of community-based, integrated health care services;
  - Reduce the overall health care and societal costs of mental health and addiction through appropriate system investments;
  - Increase the effectiveness of the integrated health care delivery system;
  - Increase the involvement of individuals and family members in all aspects of health care delivery and planning;
  - Increase accountability of the health care system; and
  - Increase the efficiency and effectiveness of the state administrative infrastructure for health care.

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## OREGON PROVIDES

- Services to prevent and/or treat the problems created by addictions, including problem gambling.
- Services to treat major mental illness such as schizophrenia, major depression, bipolar disorder and the disabling effects of childhood trauma.
- Services provided include:
  - Acute care treatment
  - Outpatient treatment
  - Residential treatment
  - Detoxification
  - Case management
  - Supportive housing
  - Supportive employment
  - Peer- and family-delivered supports

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## HOW SERVICES ARE DELIVERED

- The AMH funds services for more than 161,000 people each year through contracts with:
  - 32 community mental health programs covering 36 counties
  - Nine mental health organizations covering the entire state
  - Two state hospitals
    - Oregon State Hospital – campuses in Salem and Portland
    - Blue Mountain Recovery Center – Pendleton
- Of the total number served, 1,400 are served in the state hospitals.

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## NEED FOR ADDICTIONS AND MENTAL HEALTH SERVICES

Age/Category	In need of services	People served in public system	% of need met through public system
<b>Addiction</b>			
17 & younger	27,592	5,663	21%
18 & older	273,895	48,445	18%
<b>Mental Health</b>			
17 & younger	106,124	33,243	31%
18 & older	156,962	72,207	46%
<b>Problem Gambling</b>			
All ages	77,486	1,756	2%

Calendar Year 2009

Addictions and Mental Health Division

Prepared for the 9/13/2011 OHPB meeting

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## ADDICTION SERVICES TO REDUCE COSTS IN CHILD WELFARE *INTENSIVE TREATMENT AND RECOVERY SERVICES (ITRS)*

ITRS was funded by the 2007 Legislature to serve families affected by addiction. Its aim is to keep together or reunite families with children in foster care due to family substance abuse. This is accomplished by providing residential treatment, regular and intensive outpatient treatment, case management and clean-and-sober housing options.

- As of February 2011:
  - 1,803 children have been reunited with their parents who used services, providing a cost-offset to foster care of \$1.7 million per month.
  - More than 53 percent of children whose parents are or were involved in treatment are living safely with their parents.
  - More than 5,300 parents have used these services, and 1,700 are still enrolled today.

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## COMMUNITY MENTAL HEALTH INNOVATIONS *EARLY ASSESSMENT AND SUPPORT ALLIANCE (EASA)*

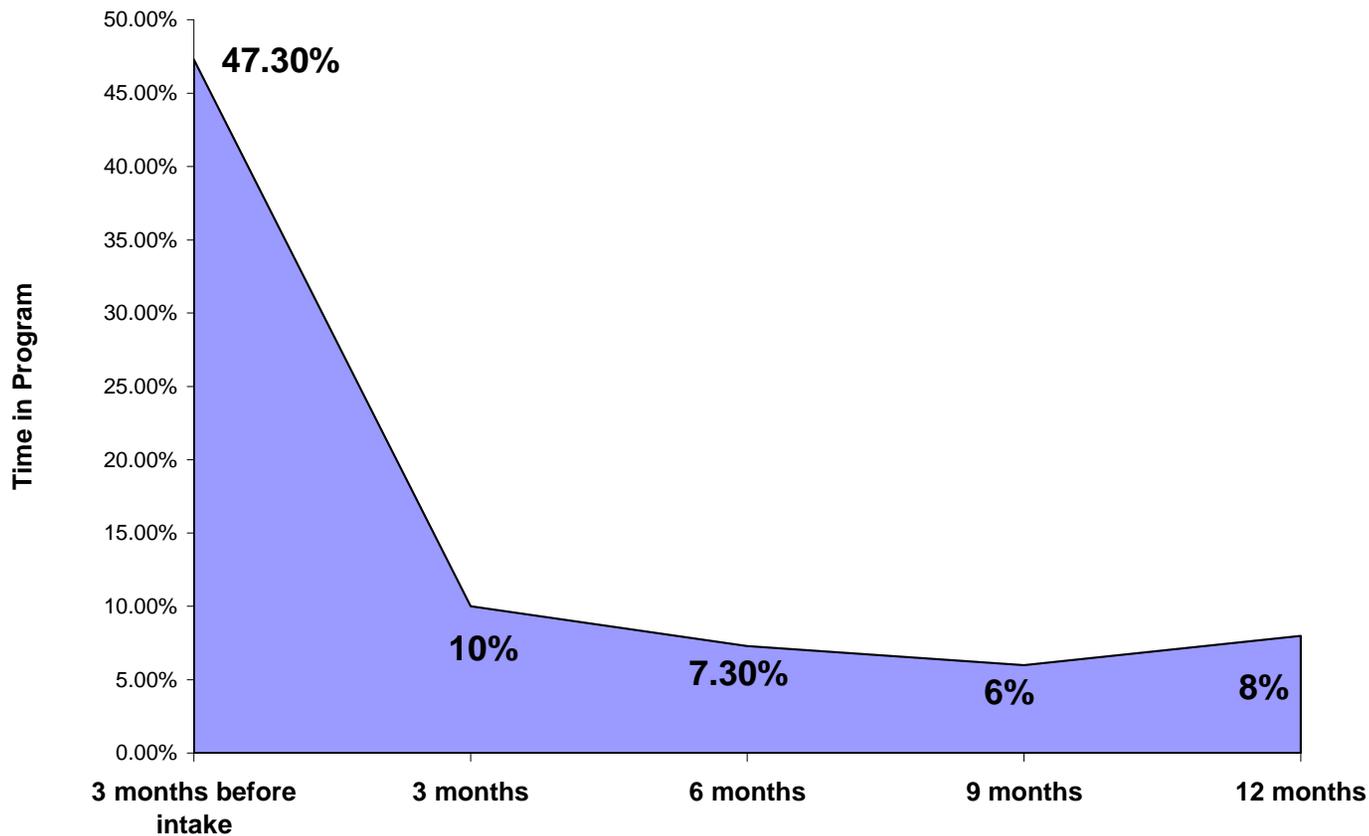
The EASA initiative identifies people in the early stages of schizophrenia and other psychotic disorders and ensures they and their families have the proper resources to effectively deal with the illness.

- From January 2008 through December 2010
  - 1,200 referrals were made to the programs
  - 425 individuals and families were accepted into ongoing services
  - The remaining 775 received case management and tertiary services
  - 28% of those served are under age 18
- Outcomes include
  - Increased employment (33% at nine months. vs. 19% at intake) among adults
  - 79% reduction in hospitalizations
  - Dramatic decrease in arrest or incarceration in first three months of service compared with three previous months (13% to 1.9%) among adults

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



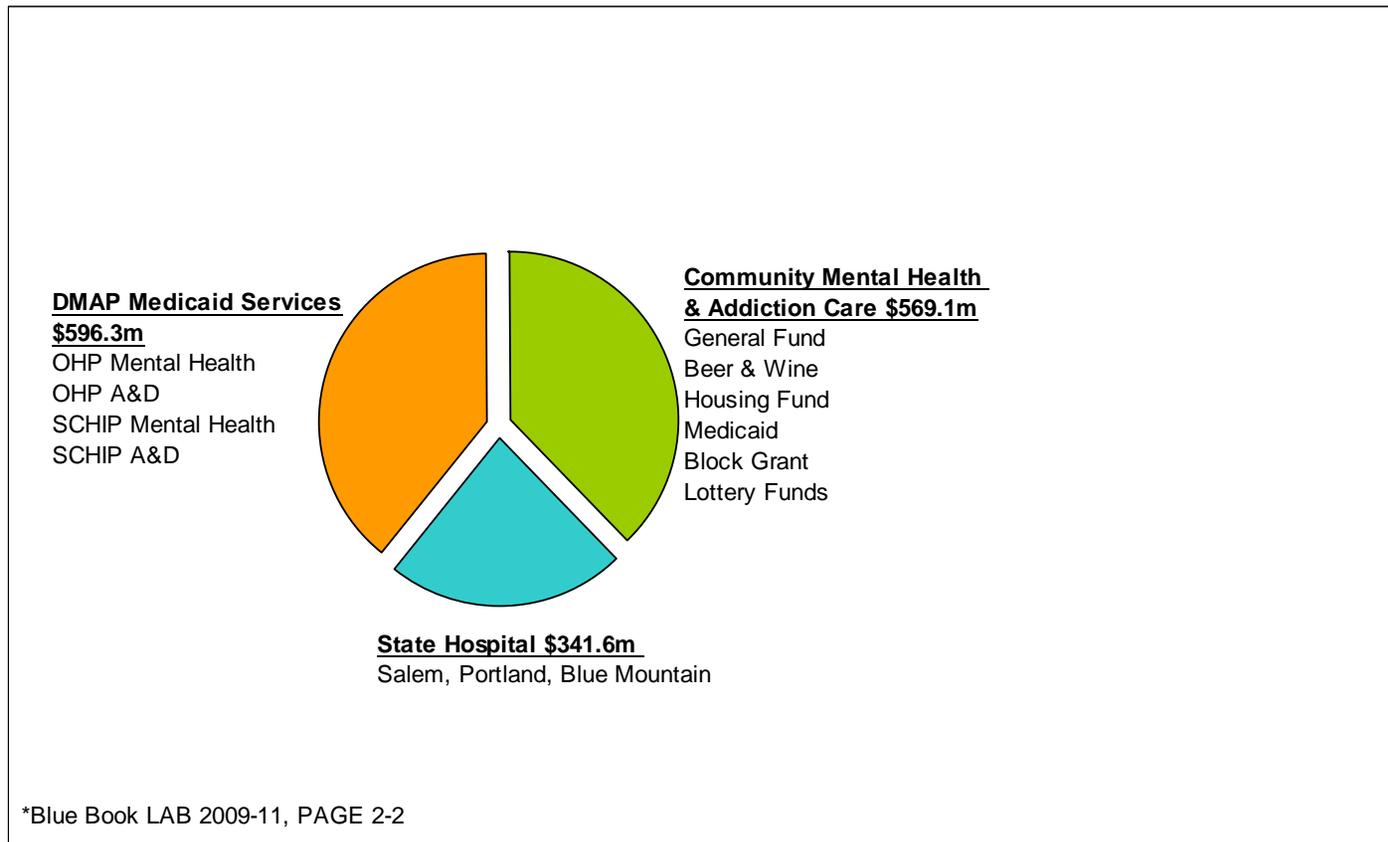
**Percent of EASA Clients Hospitalized by Time in Program**  
**EASA Clients in Service 12 Months (n=150)**



# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



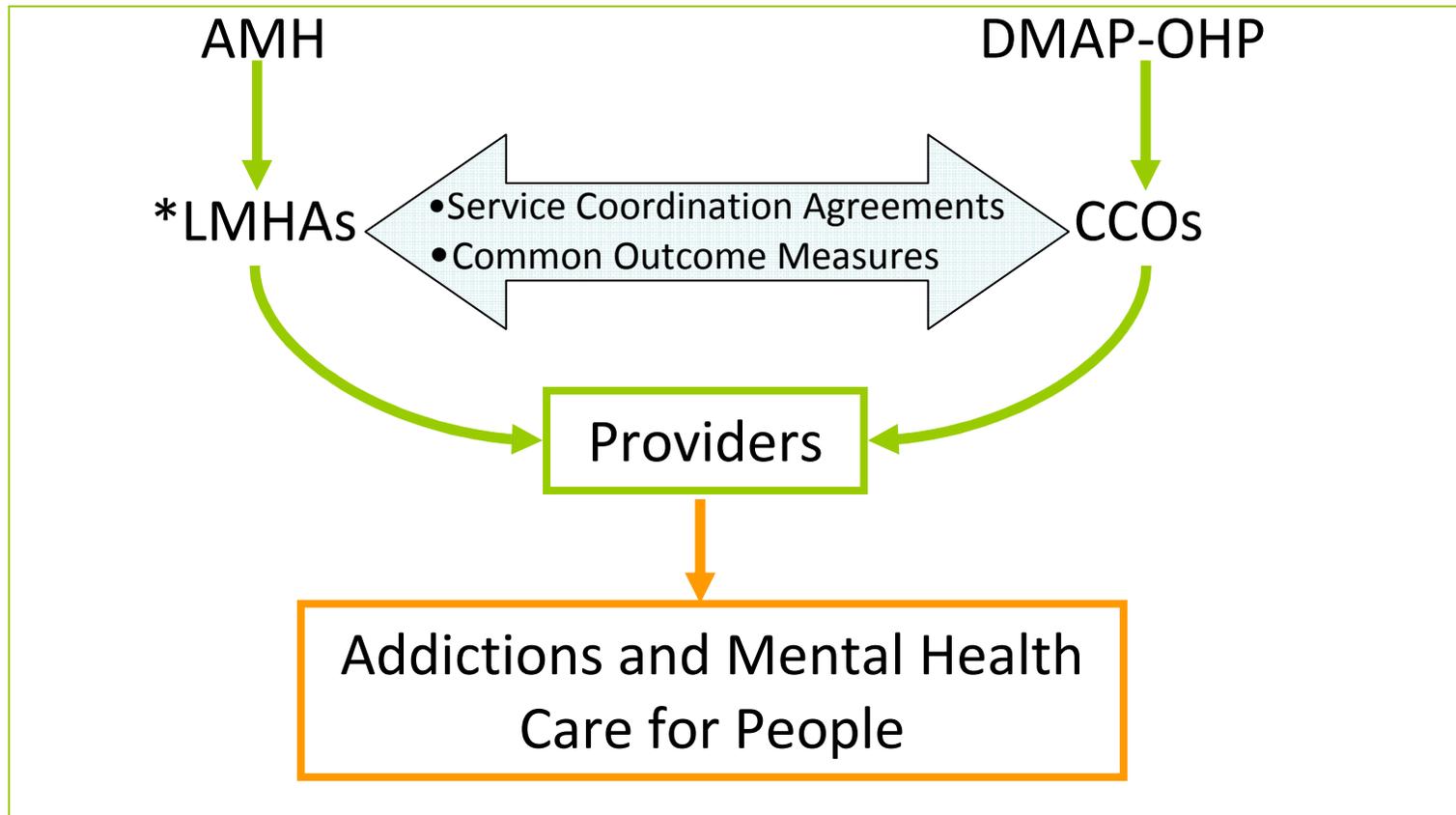
## 2009-2011 MENTAL HEALTH & ADDICTION EXPENDITURES\*



# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## FUTURE ADDICTIONS & MENTAL HEALTH CARE SYSTEM



\*LMHA is Local Mental Health Authority

Addictions and Mental Health Division

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## MENTAL HEALTH CLINICAL CLASSIFICATIONS (CCs)

### Top 15 Clinical Classifications (CCs) by Quarter

#### Managed Care CC

Category Type of Service	Quarter 3 2009	Quarter 4 2009	Quarter 1 2010	Quarter 2 2010	Quarter 3 2010	Quarter 4 2010	18-mos total	Monthly average	24-mos projected
Mood Disorders	\$17,175,566	\$15,672,937	\$19,827,931	\$20,138,968	\$18,212,026	\$21,346,568			
							\$112,373,996	\$6,243,000	\$149,831,994
Schizophrenia and Other Psychotic	\$13,682,602	\$10,381,095	\$12,293,275	\$12,309,981	\$11,430,146	\$12,227,352			
							\$72,324,451	\$4,018,025	\$96,432,601
Anxiety Disorders	\$11,736,579	\$11,141,214	\$12,552,763	\$13,139,775	\$12,409,654	\$13,811,940			
							\$74,791,925	\$4,155,107	\$99,722,567
							<b>Sub Total Managed Care CC</b>		<b>\$345,987,162</b>

#### Fee-for-service CCs (excludes crossover claims)

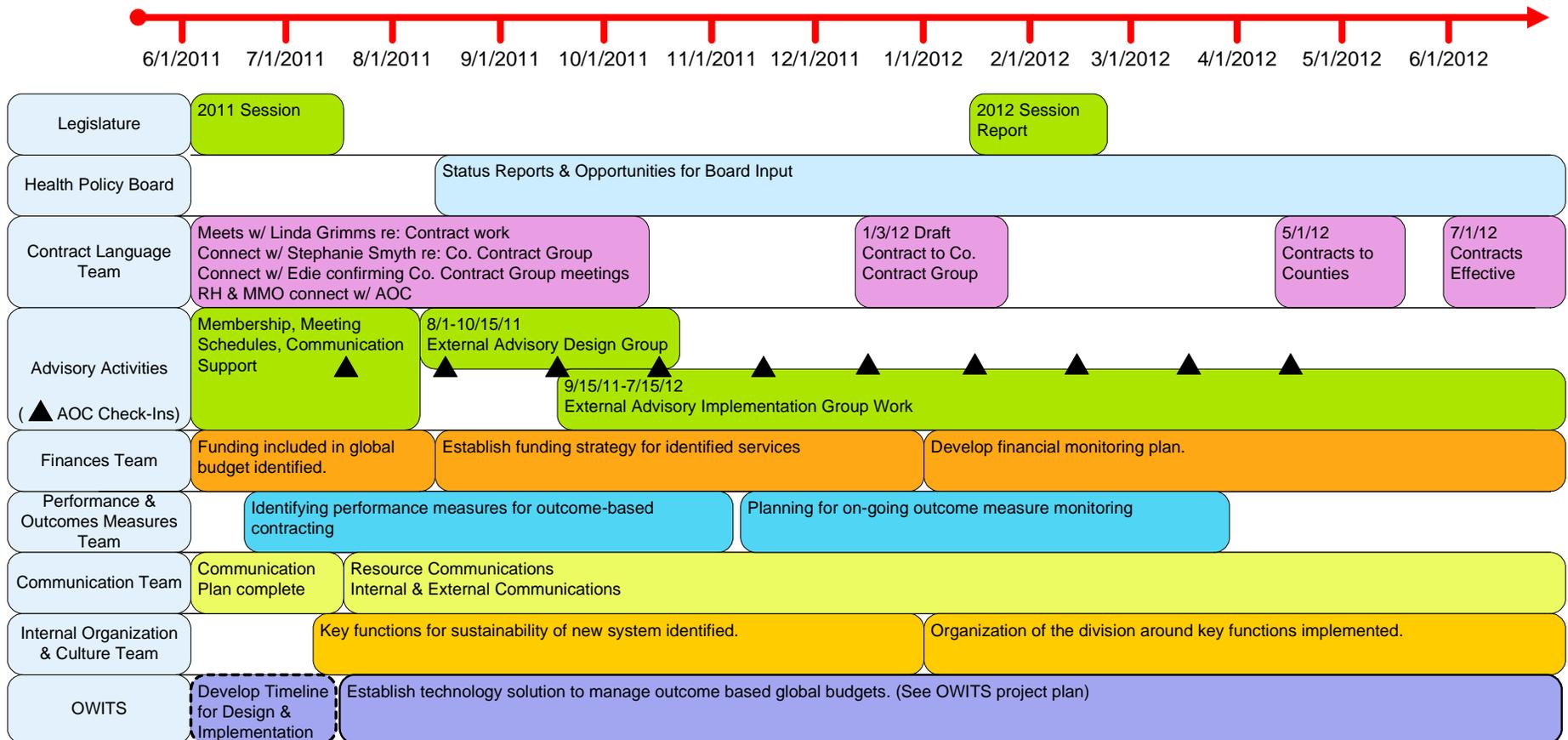
Category Type of Service	Quarter 3 2009	Quarter 4 2009	Quarter 1 2010	Quarter 2 2010	Quarter 3 2010	Quarter 4 2010	18-mos total	Monthly average	24-mos projected
Mood Disorders	\$3,024,711	\$3,100,399	\$3,124,486	\$3,143,723	\$3,175,686	\$3,044,846			
							\$18,613,851	\$1,034,103	\$24,818,468
Schizophrenia and Other Psychotic	\$2,493,259	\$2,862,240	\$2,641,582	\$2,662,220	\$2,581,380	\$3,147,952			
							\$16,388,633	\$910,480	\$21,851,511
							<b>Sub Total FFS CCs</b>		<b>\$46,669,979</b>
							<b>Total 2009-2011 Estimated Managed Care &amp; FFS</b>		<b>\$392,657,141</b>

Estimated for 2009-2011 biennium based on 18-months  
DMAP Dashboard data from April 2011

# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## AMH SYSTEM CHANGE TIMELINE



# ADDICTIONS & MENTAL HEALTH SYSTEM CHANGE



## AMH SYSTEM CHANGE STRUCTURE & GOVERNANCE

### AMH System Change Group

Members of this group include Team Leads, AMH Exec Team members, and those who are engaged with the greater OHA Health System Transformation work. Members are responsible for cross communication with their programs. This team will provide consistency and will strengthen resources and structure for the reform work.

### AMH System Change Team Lead

*Mike Morris/ Jeannine Beatrice providing Project Management*

Leads the work of staff teams and works with key informants to build the new AMH health care system, meets with Team Leads individually and as a group weekly; informs & aligns with the OHA System Transformation work.

### AMH System Change Steering

This team is responsible for championing the work, providing leadership and messaging, and inspiring a shared vision for the work. Members meet weekly and includes Mike, Jeannine, Madeline, Len, Karynn, Karen, & Richard.

### AMH System Change Support

Supports scheduling and tracking final documentation. Tracks decisions, agreements, team contacts, and supports the Communication Team work.

Lead: Diane Duncan

### AMH System Change Advising Activities

Community partners are critical to the reform efforts. Their participation is vital to the quality and success of this work. These are coordinated activities with community partners for the purpose of designing, planning, and implementing the system changes.

Lead: *Jane-ellen Weidanz*

### System Design Team

Lead: *Michael Morris*

This team develops how the components of the addiction & mental health system will work and what it will look like. Team Leads, Financing, & Advising Activities will inform this team.

### Internal Organization/Culture

Lead: *Eddie Woods*

This team will inform leadership about how to best ready and organize staff for new roles that system changes bring. The team will create a sustainability plan, which will include health care system accountability. System Design, Contract Language, Financing, Outcomes, and Communication Teams will inform this team.

### Technology Structure & Partnership with OWITS Work

Lead: *Jon Collins with OWITS project manager*

This team will build a data system, used by providers and AMH staff for tracking and reporting on the system of care including contracts, invoices/payments, and client-level data such as outcomes & utilization. Contracts and Performance work will inform this team.

## AMH System Change Staff Work Coordination

### Contract Language

Lead: *Cissie Bollinger*

This team develops language for contracts with LMHAs. Language will include service expectations and performance outcomes. Financing, Outcomes, & System Design work will inform this team.

### Financing

Lead: *Jay Yedziniak*

This team will determine funding strategy and funding allocation for a system of addiction and mental health services and supports. Team will identify funding streams and mechanisms for tracking. System Design and Contract work will inform this team.

### Performance & Outcome Measures

Lead: *Jon Collins*

This team will develop performance and outcome measures for providers to track and report. System Design and Financing work will inform this team.

### Communications-External & Internal

Lead: *Karynn Fish & Greta Coe*

This team will develop and manage communications with stakeholders and internal workforce; includes formal communication planning and website management. All teams will inform communication work.

Team Leads meet individually and as a group with the Project Lead weekly. Team Leads are responsible to document project plans with deliverables, timelines, and on-going progress. Project plans, progress, barriers, and agreements will be reviewed in the individual meetings. The weekly Team Lead group meetings provides cross information opportunities to problem-solve and coordinate work between the teams. Memberships on work teams depends on the tasks that need completion and membership can be fluid as needed.

Oregon  
Health  
Authority

September 13, 2011



# Oregon Health Leadership Council

## “Big Idea” Work Underway

Presented to the  
Oregon Health Policy Board

Greg Van Pelt



## Background

- Commissioned by the business community in the summer 2008
- Purpose—Develop solutions and actions to keep health care costs and premium increases closer to the CPI
- Statewide membership includes: 8 major medical groups, 8 major hospitals/health systems, 12 local and national health plans, OMA and OAHHS
- Director of the OHA, also participates in the Council
- The Council reports progress to the business community on a quarterly basis



## Work underway—early work

- High Value Patient Centered Care, medical home pilot for highest risk patients in 5 health plans, PEBB, OEBC, OMIP and some DMAP—3600 patients participating
- Value Based Benefit Design developed—EVRAZ, ODS, OEBC and PEBB early adopters; 4 plans offering
- Collective initiatives to address high cost imaging, acute low back pain, reducing elective deliveries before 39 weeks
- Reducing administrative costs through implementation of a single, secure sign on for physicians to transact business; completed the eligibility and claims companion guides for the OHA; effort on credentialing
- Metrics to measure effectiveness
- And....recognition that we needed to do more



## The “Big Idea” Work Group

- Growing concern of the budget reductions to Medicaid and impact on business through the cost shift
- Needed to launch something more transformational
- Small group of OHLC began work late 2010
- Need for more significant re-design of the delivery system
- Explored four models
  - Public Utility Model
  - Franchise Model
  - Health Commons Model
  - One Medicaid Model
- Recommended to OHLC the “Commons” model approach to deliver on the triple AIM for the Medicaid and uninsured populations
- Recognizing the approach would look different in each region, but some value in collective statewide effort



## Moving the “Big Idea” Forward

- The new “Commons” delivery system envisioned would be:
  - community based,
  - collaborative/joint mission
  - includes shared responsibility, risk and funding
  - selective contracting with high performers
  - sustainable practices responsive to community needs
- At the same time OHLC work going on, the state transformation work started
- Elements consistent with the CCO design
- To take the next steps, the OHLC determined we needed further design of the system, assess the feasibility of this approach and a develop a sound business plan to execute



## Moving the “Big Idea” forward

- Needed independent third parties to do this work quickly, by the end of the year, to be prepared for 2012
- Funded by the OHLC, Portland based hospitals, health plans, MCO’s, 3 counties and OHA
- Contracted with Milliman and Health Management Associates to provide analysis and support in:
- Identifying best practices locally and nationally in serving the Medicaid and uninsured populations
- Determine the care and financial gaps that exist
- Recommend a delivery and financing model and business plan with specific recommendations for the greater Portland area
  - Data and framework could be used statewide



## Completing this work in this timeframe

- Needs assessment of the population
- Data analysis and benchmarking to understand the gap, opportunities
- Models developed to do scenarios
- Extensive interviews with providers, health plans, state and county administrators, business leaders
- Recommendations to a small steering group
- Final recommendations with specific work plan completed by end of year
- Commitment to make the changes necessary



## What's needed to make this work

- Recognition that this is a community issue, that no one organization can solve this problem individually
- If action is not taken now, pressure on the commercial rates will be a major problem
- The framework for change has to be the triple AIM
- Must have shared responsibility and risk with providers, plans, business, patients as part of the solution
- Coordination with the State and Legislature is key
- Willingness to act

## Coordinated Care Organization (CCO) Criteria Work Group August 18, 2011 Meeting Summary

### Discussion Topics

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The work group was divided into four smaller discussion groups to address the following questions and to identify key issues to forward to the Oregon Health Policy Board (OHPB). The questions addressed in small groups were:

- Oregon Health Authority (OHA) staff have identified these CCO certification topics for discussion at future meetings of the CCO Criteria Work Group:
  - Health equity
  - CCO governance
  - Alternative dispute resolution
  - CCO financial solvency, risk and business plan
  - Patient rights

These topics have been identified as complex, substantive and appropriate for structured discussion in this small group setting. We may identify others among the seventeen topics listed in the CCO Criteria Work Group Charter that we want to include in our discussion. Input on the remaining topics will be handled online or in other public forums. What other topics should be added for discussion? What discussion priority should these topics be given, and how should they be grouped?

- Based on the briefing paper on CCO certification (*see attached*), what process for selecting and contracting with CCOs seem best? What considerations should be foremost in deciding a certification process?

### Key Points for Oregon Health Policy Board

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- The small groups generally felt that it was not the best use of limited work group time to address Alternative Dispute Resolution. Some recommended that a technical work group within OHA develop options and recommendations for consideration by OHPB.
- Overall, the groups were satisfied with the CCO criteria topic areas, but wanted to ensure that other criteria/issues were addressed as well:
  - Organizational competencies and sustainability: this topic included the need for provider readiness assessment, need for technical assistance, and importance of providing models and baseline standards for CCOs
  - Health equity: should also include geography
  - Importance of patient engagement, patient rights and responsibilities, care management and coordination
  - Access and availability to services and supports
  - Collaboration and integration
  - Technology requirements and support
  - Patient-centered primary care homes

- Groups expressed some concern about where specific topics were being discussed (e.g., mental health and CCO relationship to counties and local mental health authorities, health information exchange (HIE)/health information technology (HIT) and related privacy issues, benefits, eligible populations?)

### **Small Group Discussion**

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#### ***CCO criteria topics***

The groups prioritized the five identified topics as follows:

- Health equity
- Patient rights and responsibilities
- CCO financial solvency/risk/business plan
- CCO governance
- Alternative dispute resolution (*suggestion that this be moved to an internal OHA technical work group and taken to OHPB*)

Additional possible criteria/considerations for discussion or staff recommendations included, not in priority order:

- Care management
- Integration of LTC in continuum of care even though not in global budget
- Implications of integration of care and innovation for the delivery system (“collaborative/innovative models”)
- HIT flexibility and assistance from state
- Coordination with federal health reform
- Measures of CCO success and consequences for not meeting these measures
- Balancing priorities
  - Specificity vs. flexibility
  - Common standards vs. regional/community characteristics
- “Growing to scale” and short-term/long-term strategies
- Consumer engagement strategies

#### ***CCO Certification Process***

Groups generally felt that there is a need for an additional option (5) that includes all elements of Option 4 plus those components of current MCO contracting process that will still serve well under health system transformation:

- Add health equity strategies as fourth key component so that process would include core criteria, integration and innovation, the business plan, and health equity strategies.
- Avoid duplication and being unnecessarily burdensome

- Focus on integration and innovation
  - Outcomes-based and linked to triple aim
  - Emphasize importance of patient engagement
  - Set of core criteria serving as foundation (must-be-met) but allow latitude to reflect community differences
  - Accountability despite flexibility and community variations
  - Address rural and state border issues
  - Include iterative interview process as part of certification
  - Address types of implementation support available
  - Focus on intangibles (culture shift, innovation, integration)
  - Health equity/disparities need to be addressed in meaningful, measurable ways and fiscal rewards should be considered for successful outcomes
  - Transparency of process and outcomes
- Consider tiered approach to achieving full CCO capability (beyond the “must-be-met” core criteria”
- Address ACA phase-in of Medicaid expansion in the CCO criteria
- Account for possibility that some CCOs may fail when trying to innovate and allow for remedies
- Care coordination and care management criteria should provide inducements to contract with appropriate set of providers, incentivize those providers, and assure effective communication

## Potential CCO Certification Process Options

There are critical success factors for a CCO to be effective and sustainable.

1. Business viability
2. Local and community framework and approach
3. Integrated, innovative and outcomes-based system
4. Other critical success factors?

### **Certification process options**

There is a spectrum of available options, each with advantages and limitations. The options summarized below illustrate several choices that would be more likely to meet federal contracting expectations as well as the framework of HB 3650

#### **OPTION 1 – Qualification and selection process:**

There are three key components of the application:

- **Core criteria:** This is an objective qualification component. Applicants would submit their qualification materials for a “pass/fail” type of review of business viability factors.
- **Integration and innovation criteria:** This component is where the applicant outlines their innovations and approaches to integration and service delivery. The specific criteria would be established in advance but the applicants may have their own approach, tailored to the demographics and health of their communities.
- **Business plan:** This component describes the applicant’s plan for operations and budget, plans for establishing and implementing alternative payment methodologies, and anticipated changes in budget and payments based on patterns of utilization.

All three components would be evaluated by OHA. Negotiations with the applicants would assure that all three aspects of the criteria are met and would serve to develop appropriate contract language. Qualified CCOs would be awarded a contract at the next contract award period.

#### **Pros:**

- Satisfies federal requirements and assures that solvency and other essential qualifications are documented for each CCO.
- CCOs will describe integration and elements of service delivery, alternative payment systems and other innovations appropriate to their identified community needs.
- Negotiations will permit OHA and the applicants to discuss how to achieve the contract objectives.

#### **Cons:**

- Requires determining how much variation within the innovation criteria is reasonable.
- This could be a more time-intensive process to assure consistency of applications with CCO criteria and because of the opportunity for negotiation.

#### **OPTION 2 – Existing process for managed care organizations:**

Existing Division of Medical Assistance managed care application process has applicants submit assurances or materials that demonstrate their qualifications to provide the covered services in service areas. Qualified CCOs are awarded a contract at the next contract award period.

**Pros:**

- The existing managed care organizations are familiar with this process.

**Cons:**

- This process does not reflect the transformed health system and is not outcomes-based.
- This process will require substantial revision and updating to accommodate HB 3650 objectives and Medicare requirements.

**OPTION 3 – CCO certification application modeled after Medicare Advantage Application:**

The Medicare Advantage (MA) process consists of an application involving either “attestation”, “attestation with supporting documentation” or a narrative or other information, along with a price submission. The MA application collects information about business aspects and provider capacity. It does not require information about the applicant’s Medicaid line of business.

Applying this option, OHA would develop a certification application that parallels the MA application. If the CCO applicant is also applying as an MA plan, the applicant could submit: (a) a copy of the MA application submitted to CMS and (b) additional materials pertinent to the Medicaid line of business. Applying this option, qualified CCOs would be awarded a contract at the next CCO contract award period.

**Pros:**

- The MA application is well-organized and structured to obtain most of the core business information that OHA will require for the contracting process.
- This option would reduce administrative burden on CCOs serving members who are eligible for both Medicare and Medicaid.

**Cons:**

- This application process does not provide a process for addressing the integration, innovation and outcomes-based aspects of HB 3650, nor does the MA process require submission of a business plan.
- Not all CCO applicants will be MA plans; some may simply contract with MA plans (which may be an affiliate).

**OPTION 4 – Combine Options 1 + 3**

- Use MA application approach for core criteria (Option 3)
- Use the Option 1 integration and innovation criteria and business plan (with negotiation)

**Pros:**

- Use the best of options 1 & 3, simultaneously streamlining and assuring the adequacy of the qualification process.
- To the extent feasible to meet OHA needs, reduce duplicated application processes as between OHA and CMS
- Could be seen as a positive model by CMS, since it is already familiar with the MA application process.

**Cons:**

- See prior discussion

## **Global Budget Methodology Work Group August 17, 2011 Meeting Summary**

### **Discussion Topics**

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The work group was divided into three smaller discussion groups to address the following questions and to identify key issues to forward to the Oregon Health Policy Board.

- What are the two highest priority topics that the global budget methodology work group must discuss over the next few months (i.e., what are your two top concerns)?
- Working from the initial list of program inclusion/exclusion considerations (attached), what are the two highest priority considerations for determining which programs should be included in the initial Coordinated Care Organization (CCO) global budgets?

### **Key Points for Oregon Health Policy Board**

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The small groups generally agreed that the following topics for future meetings are the right ones for this work group, although some felt that there was little need to address ACO implementation as part of these discussions:

- Program Inclusion/Exclusion Considerations
- Managing Risk and Ensuring Outcomes
- Assuring Sustainability
- Medicare Integration and ACO implementation

The groups added that the following should also be addressed somewhere in the transformation planning process:

- Scalability (will the methodology work as other payers are folded into the CCO construct?)
- Process for revisiting and/or revising the global budget methodology over time
- Redesign of internal state systems (e.g., OHA) to support the transformation to CCO global budgets and CCO operations under global budgets

The small group discussion of what considerations are important when weighing programs to include or exclude from global budgets focused on:

- Alignment of incentives to reach the Triple Aim
- Definition of outcome targets and using them to inform inclusion of programs
- Consideration of the nature of program costs (e.g., Are they predictable or highly variable? Do they have high fixed costs in relation to variable costs?)

### **Small Group Discussion**

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#### ***Global budget issues for work group discussion***

The discussions within the small groups varied widely and provided very broad insight into the concerns and priorities of workgroup members. The following bullets provide an overview of the variety of issues raised.

### *#1 - Program Inclusion/Exclusion Considerations*

- Many members felt that we could miss the opportunity to maximize integration when we exclude programs. All modes of care—physical, medical, dental—should be included
- A decision-tree could be helpful to guide what is excluded and included. Priorities for inclusion include:
  - Programs that are well-integrated with physical, mental health
  - Programs that are macro-economically feasible
  - Programs that are prevention-oriented
  - Programs that have the potential to yield highest health outcomes and largest cost-reduction long-term.

### *#2 - Managing Risk and Ensuring Outcomes*

- A lot to unpack under this heading in order to ensure that incentives are meaningful, aligned, and measurable incentives to promote Triple Aim objectives.
- Risk Discussion
  - Questions were raised about the desirability and enthusiasm around assuming risk. Some communities clearly expressing they are interested; other groups may not be so willing.
  - There was a good deal of discussion on the importance of risk management and risk-sharing. Members requested to get information on one or more models for what exactly is the risk, what kind is it, who will share it and how?
  - Need to consider risk being shared between state and federal, but also between state and CCOs, and potentially within the statewide CCO infrastructure and between the CCO and the community.
  - Concern expressed regarding county government/local public health financial risk if CCOs fail to address health needs of county residents.
  - Several members raised the issue of including consideration of the benefit package in the management of risk.
- Financial and Health Outcomes
  - Global budget should be tied to performance against financial and health outcomes, with a feed-back loop so that information on performance is as immediate as possible. Performance based as well as evidence based.
  - Need to have the tools to reduce costs and manage outcomes (e.g., community support, full member participation, sound measurements, and systems that communicate effectively).
  - Return on investment is a critical measure at both state and community levels.
  - Performance targets must be reasonable and attainable.
  - Sub-standard outcomes must be managed. If a community facility fails to meet outcomes measurements, the next step should be an improvement plan rather than simply shutting the facility down.
- Incentives and Shared Savings

- Reward sharing (including savings sharing, but broader than just that) will be important. Also critical to prevent cost shift, to/from State Hospital, to/from long term care, or elsewhere.
- May be necessary to reward good performance at the community level and create rewards as an economic development strategy for the respective communities.
- Specific incentives should be established for CCOs to focus on the management of members with the highest risk in terms of chronic conditions and costly services.

### *#3 - Assuring Sustainability*

- There was a good deal of discussion on using proven industry standards and not “reinventing the wheel.” Several members offered this would support sustainability and that not doing so will increase administrative costs and jeopardize sustainability.
- Agreement that it makes sense to examine models that have been successful.
- One consideration that kept emerging as a theme to consider into the future for global budgeting was short-term versus long-term savings/incentives. Items that realize short-term savings may not be best for long-term outcomes. The intersection of outcomes and savings needs to be considered.
- Necessary to identify what the funding streams will consist of and have predictable budgets that instill a baseline target with a reliable trend and an additional percentage for good performance.
  - What is the reliability of federal funding levels and how can the state address it?
  - Smoothing out variations and risks important, perhaps through a stabilization fund that carries over from budget period to budget period.
  - Need to assure that predictable funding does in fact lead to program success, not just program “comfort.”
- Can accountability for the global budget be placed at the community rather than CCO level? If so, is it reasonable to expect that local funds might be used to supplement the global budget to meet community health goals?
- Implications go beyond Medicaid – how about a “more global budget”?

### *#4 - Medicare Integration and ACO Implementation*

- Some group members did not see a strong need to explore ACO implementation during the three remaining meetings; several strong comments were brought questioning the insurance capabilities, transparency and simplicity of ACOs, as they’ve seen them to date, and the long-term feasibility of this model was questioned. Members asked for a white paper or similar briefing to provide some background on ACOs. Others did express concern over alignment on metrics and other requirements where possible.

### ***Focused Discussion of Program Inclusion/Exclusion Outcomes Considerations***

The breakout groups were asked to review a proposed list of considerations around which programs are included in initial global budgets. The following outlines discussion points.

Focus on the alignment of incentives to reach triple aim:

- Perverse Incentives: Would the exclusion of a specific program from CCO global budgets create an incentive for CCOs to cost shift away from services included in the global budget towards carved out services.
- Value centered approach: Both high-value and low-value services should be included in CCO global budgets to provide the opportunity for CCOs to shift resources from low-value services to high-value services.
- Addressing Market Power: By including or excluding a program from CCO global budgets, would provider market power be addressed in such a way that could lead to lower negotiated rates?

Define outcome targets and use to inform inclusion of programs:

- Outcome centered approach: What services are in or out could be determined by outcome targets for which CCOs are to be held accountable.
- Impact on health: Does the service directly impact health outcomes (e.g., probably doesn't make sense for GME to go through CCOs)?
- Trade off between CCO flexibility and program consistency: Despite a general preference for CCO flexibility in order to allow innovation, this could also lead to broad disparities in terms of access and quality under different CCOs. Clear and consistent outcome expectations could help mediate that tendency.

Nature of program costs:

- Uncertainty of program costs: Are the program costs predictable or highly variable?
- Fixed Costs & Non-rival services: Programs that are generally centralized, have high fixed cost in relation to variable costs, and can be shared across CCOs should likely be carved out. (e.g., statewide toll-free tobacco quit line). Conversely, highly localized services that are difficult to share across CCOs and have high variable costs relative to fixed costs should be included (e.g. non-emergency transportation).

Other discussion points on exclusion/inclusion considerations:

- Global budgets need to include more than just Medicaid.
- Focus on programs that will integrate effectively and have larger utilization and budgets to get increased economies of scale.
- Consider the funding streams whether federal, state, or local.
- Pooling community funding and PEBB into the mix was discussed as a consideration. This will create more of a comprehensive approach to care that is needed for the success of Oregon's Transformation efforts.
- How current FFS populations/programs will be integrated and goals for reducing FFS must to be addressed, with attention to volatile populations.
- Considerations for programs should include the following:
  - ROI
  - Urban vs. rural – access to care

- Use of national best practices
- Performance based vs. evidence based
- Cultural competency
- Transparency in determining was a big concern regarding what is included or excluded, and broader transparency in the governance of this new system and how it operates.
- How to ensure coordination with important services that are out (e.g., social services such as supportive housing that have a strong influence on health outcomes over time).
- Need to plan for change over time in what is included and excluded from global budgets to allow them to evolve and self-correct.

***Additional thoughts that emerged from workgroup discussions***

- Oregon should have ownership of its citizens and focus on the lifelong continuum of care.
- Care should be coordinated in a way that will transcend beyond the Medicaid enrollment period, which involves true integration of community support.
- What are the latest figures on average length of enrollment on OHP? Is this increasing due to poor economy/erosion of employer-sponsored insurance? What are the implications for cost shift? Inclusion/exclusion?
- Users of health care services need to be involved in how they receive care and be provided more directives in how to access care, levels of care, and costs of care.
- Imperative to sustainability is that the new system should have a community-based approach built from the bottom up in an effort to gain community engagement in taking responsibility for members. A “bottom up” approach will focus on community engagement and encourage the use of those services, which will support lower costs in care.
- If assumption is that a person’s treatment plan shouldn’t depend on health insurance status, then how can community-based approach deal with loss of Medicaid enrollment?
- What will federal reform expansion of Medicaid mean to stability of Medicaid enrollment by 2017?

**Global Budget Methodology Workgroup  
Discussion Document  
Considerations for Program Inclusion/Exclusion in Initial CCO Global Budgets**

House Bill 3650 intends for federal and state funds that support the access, quality, and delivery of care to Medicaid enrollees in Oregon to flow through global budgets for Coordinate Care Organizations (CCOs). Long term care and mental health drugs are specifically excluded, but otherwise, Oregon needs to determine the breadth of funding streams and programs that will be delivered through CCOs.

Below is an initial list of considerations for discussion that may be helpful in sorting out where services should be excluded from the initial CCO budgets. As CCOs further develop, initially excluded programs should be considered for inclusion. (Note: Whether a program is initially within the global budget should not be confused with funding for the program/services. All funding decisions depend on the legislatively enacted budget.)

**Draft Consideration List:**

- 1. Is the program integral to carrying out health care transformation in HB 3650?**
  - a. To what extent does the program contribute to the goal stated in HB 3650 that coordinated care contracts focus on
    - a. prevention,
    - b. improving health equity and reducing health disparities,
    - c. utilizing patient centered primary care homes,
    - d. evidence-based practices, and
    - e. health information technology
  - b. Could this program be carried out more efficiently in an integrated setting?
  - c. Would integration of the program improve the overall ability of consumers and purchasers to hold CCOs and providers accountable for appropriate care?
- 2. Should a program be temporarily excluded from CCO global budgets? If so for how long?**
  - a. Will CCOs need to develop expertise, relationships, systems and infrastructure necessary to manage this program? How much time will this take?
  - b. Will the state need to develop capacity to hold CCOs accountable for appropriate care and/or outcomes associated with this program? How much time will this take?
  - c. Will the program need to unwind blended funding streams or services to clients who will not initially be served by CCOs? How much time will this take?
- 3. Should some CCOs be allowed to exclude the program from their global budget and others not?**
  - a. Do potential CCOs exhibit different levels of readiness to carry out the program?
  - b. Does the program vary geographically to a significant degree?

## Outcomes, Quality, & Efficiency Metrics Work Group August 22, 2011 Meeting Summary

### Discussion Topics

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The work group divided into three smaller discussion groups to address the following questions and to identify key issues to forward to the Oregon Health Policy Board. Questions about the performance measurement principles and domains (*see attached*) were:

- Are the outlined principles for selection and retirement of performance measures the right set? Are the selection and retirement criteria appropriate to the principles? Which principles are most important?
- Are the outlined domains of accountability the right ones? Are there topic areas or important issues missing within the domains?

### Key Points for the Oregon Health Policy Board

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- The performance measures selected should help drive transformation; that is, they should help Coordinated Care Organizations (CCOs) to focus on issues of integration, coordination, and efficiency, among others.
- Feasibility and burden of data collection, and comparability with measures used in other states are issues to keep in mind when selecting performance measures, but these considerations do not outweigh the need to measure what matters. As one participant said, “We need to move from measuring what we can to measuring what we should.”
- Many participants emphasized the importance of ensuring that CCOs engage with a broad array of community partners and make some effort to address the social determinants of health.
- Consumer education (e.g. the degree to which a measure helps to communicate the goals of transformation to consumers) should be added as a criterion by which to judge potential measures.
- The issue of time frame came up both directly and indirectly: what expectations and related performance measures will OHA have for CCOs in the first years of their operation vs. 5-10 years out?

### Small Group Discussion

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***Principles and criteria to use when selecting or retiring CCO performance measures (See attached)***

#### *General Comments*

- The proposed principles and related criteria seemed to be generally acceptable to participants although group members had several suggestions for issues that should receive greater emphasis, or criteria that should be re-worded or combined (see comments by principle below).

- A few additional principles were suggested:
  - **Relevance for transformation** – many participants felt that potential performance measures should be evaluated based on their potential to help drive the kind of system realignment OHA is hoping to see. This was a priority principle for many. There was concern that, in the absence of a specific principle around transformative potential, the metrics identified would tend to reinforce the status quo or be too heavily weighted toward measures of minimally acceptable performance.
  - **Consumer education** – more than one group raised the issue of public education and the need to engage consumers in the transformation effort. In terms of a criterion by which to evaluate potential metrics, we might ask how well the measure communicates to consumers what is expected of CCOs. (This could be a component of the proposed “relevance” principle.)
  - One group commented that the overall approach to CCO performance measures needed to be flexible and nimble, that OHA needed to re-examine measures on a regular basis and be willing to make changes to the measures as circumstances warranted. Changing the phrase “retirement criteria” to “revision criteria” or something similar might help to communicate a sense of flexibility.
  - Another group suggested replacing the word “criteria” with “guidelines.”

*Principle #1 – Relevance and value*

- Comment that relevance and value should be considered from a wider perspective than just OHA’s or providers’ viewpoints.
- Comment that this could be considered two separate principles, especially if “value” relates to costs.
- Suggestions for re-wording of the criteria under this principle:
  - “Best practices” should be replaced with “evidence-based,” with the caveat that evidence may be lacking in some cases where research has not been supported, particularly around health disparities.
  - Add ‘access,’ ‘prevention,’ ‘social determinants of health,’ and ‘patient experience/engagement’ to the list of relevant issues that measure may capture.

*Principle #2 – Consistency with existing measures*

- There was support for this principle from the perspective of minimizing reporting burden and enabling comparisons with other systems, but many participants commented that Oregon will need to venture into new territory (either on measures or benchmarks) to reflect the innovation of CCOs.
- One group commented that internationally used measures—not just ones used nationally or in other states—should be considered as sources.

*Principle #3 – Attainability*

- One group commented that attainability was closely linked to “actionability”; that is, a measure is only attainable when a CCO can look at it and know what actions to take to improve performance.
- One comment that attainability might overlap with feasibility.

*Principle #4 – Sensitivity*

- Some objections to the criterion proposed under this principle that measures should reflect changes in CCO performance “within a reasonable time frame” because of the feeling that the most important outcomes may be 5 or 10 years out.

*Principle #5 – Feasibility of Measurement*

- There was a fair amount of discussion on this topic, with one group identifying this principle as the most important. Some participants focused on limitations (e.g. “In eastern Oregon, 40% of providers will likely never adopt EHRs, so how can we measure the process of care coordination for those providers?”) while others commented that the availability of data should not drive decisions about what should be measured (e.g. “we need to move from measuring what we can to measuring what we should”). Overall, the group seemed to favor a balanced approach.
- Comments regarding building on existing data sources:
  - Things that are feasible aren’t necessarily useful; first determine what we want to measure and then determine how feasible it is.
  - Claims data, including APAC, will meet some of our data needs but have shortcomings: they miss some populations (uninsured, etc.) and do not necessarily get to outcomes, care coordination and other aspects we’d like to measure under transformation. Need to move beyond claims.
  - Data availability will vary across the state but we can’t only select metrics that work for everybody, because then we won’t have anything.
  - Build on some of the metrics that plans already collect and collect data as efficiently as possible when it will come from sources other than claims or EHRs.
  - One group raised the issue of how Medicaid churn, member choice, and overlapping CCO target populations would affect performance measurement and the ability to hold CCOs accountable for outcomes. This issue relates also to the proposed reasonable accountability principle.

*Principle #6 – Reasonable accountability*

- Some participants commented that this principle seems to favor a short-term perspective rather than a focus on longer-term health or health impacts.
- See also last bullet under *Feasibility* above.

*Principle #7 – Performance measures cover range of CCO populations and services*

- One comment that this principle might be more effectively labeled “diversity of measures.”

*Miscellaneous*

- There was one comment that the principles for selecting CCO performance measures did not express a sense of urgency. Possibly this could be reflected in a principle related to timeliness, although the urgency may pertain more to the larger transformation initiative than to selection criteria for CCO performance measures.
- One group noted that there may be a need for some CCO-specific performance measures that are relevant to the region or population being served; this would make performance measurement more meaningful to members.
- Suggestion to review the principles to make sure they would not exclude potential measures addressing disparities, such as training around cultural competency.

***Domains of CCO accountability that should be measured (See attached)***

*General Comments*

- In addition to the domains listed on the discussion document, participants suggested these topics:
  - **Community orientation** – participants in more than one group expressed interest in assessing how well CCOs engage their community partners and help members utilize a broad array of services. In one group, there was an explicit desire to assess community orientation in relation to CCOs’ ability to address the social determinants of health. It was noted that this may run up against the principle around feasibility of measurement.
  - **End of life care**
  - **Prevention**, both primary and secondary
- In a few cases, participants suggested domains or topic areas that were already listed with slightly different wording. These suggestions included: consumer or member perspective/satisfaction and engagement (a.k.a. patient experience and activation); access to care; coordination; and integration.
- The suggestion was made to consider measuring some topics—particularly those topics for which performance measures are less mature—on a “test” basis. Under this arrangement, baseline data would be generated and CCOs would build measurement capacity before being held accountable for the results.
- Another participant suggested starting with a “core” set of the most important and measureable measures and building out from there over time.
- One group objected to listing out specific services areas for measurement (e.g. mental health, dental, etc.) and suggested measurement in “all populations, all settings, and all service areas” instead.

- Groups also offered comments on specific topic areas, as noted below.

*Inpatient, outpatient*

- Make it clear that refers to physical health

*Integration*

- Measures should capture three aspects of integration: 1) integration of physical, mental, and dental health services; 2) integration of non-medical determinants of health with medical care, 3) integration of care across a lifetime of care (vs. episodic treatment).
- Care transitions are an important topic in this domain.

*Access*

- Measurement of access should also account for appropriate utilization. Need to go beyond theoretical access to measure whether people are actually using and engaged in the services offered and whether CCOs are making efforts to reach out, detect and diagnose health issues. This is particularly relevant for disparities.

*Equity*

- For both equity and access issues, it is just as important to get data on who is not getting care as it is to get data on what care others are getting.

*Efficiency and cost control*

- Measurement of CCOs' performance in this domain should apply to both the provision of services and CCO administration.
- Duplication and location of care are topics of interest here.

*Patient experience and activation*

- It was noted that "patient" should be changed to "member."
- Patient activation was an unfamiliar concept for many.

*Miscellaneous*

- Questions were raised about how public health fits into the CCO model, particularly in reference to the scope of outcomes for which CCOs should be held responsible.
- One group saw little value in the theoretical separation of accountability for transformation vs. accountability for system performance. However, another group appreciated the split. Participants in the latter group commented that measures under system performance were likely to be well-known/well-established ones that should be retained to enable examination of performance trends over time, whereas measures under transformation were likely to be of most interest for assessing the CCO model.
- A question about structure vs. process vs. outcome measures in one group was answered by noting that, while the long-term goal is to focus on outcome measures, metrics of all three types will likely be needed for the foreseeable future. This is consistent with the Incentives & Outcomes Committee direction from 2010.

**Wrap-up**

- One participant observed that thinking about performance measures was challenging when it was not clear what CCOs would look like and requested substantive information or updates from the other workgroups.

## Proposed Domains of Accountability Discussion Document

OHA should assess CCO performance in two primary domains:

1. Accountability for **system performance** in all service areas for which the CCO is responsible:
  - a. Adult mental health
  - b. Children's mental health
  - c. Addictions
  - d. Outpatient physical
  - e. Inpatient physical
  - f. Dental
  - g. Prevention
  - h. End-of-life care
  
2. Accountability for **transformation**:
  - a. Care coordination and integration
  - b. Patient experience and activation
  - c. Access
  - d. Equity
  - e. Efficiency and cost control
  - f. Community orientation

## CCO Accountability Metrics Discussion Document

### Proposed Principles for Selection and Retirement

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

Principle	Selection criteria	Retirement Change criteria
Transformative potential	<ul style="list-style-type: none"> <li>Measure would help drive system change</li> </ul>	<ul style="list-style-type: none"> <li>Measure reinforces the status quo rather than prompting change</li> </ul>
Consumer education	<ul style="list-style-type: none"> <li>Measure successfully communicates to consumers what is expected of CCOs</li> </ul>	<ul style="list-style-type: none"> <li>Measure is not understandable or not meaningful to consumers</li> </ul>
Relevance <del>and value</del>	<ul style="list-style-type: none"> <li>Condition or practice being measured has a significant impact on issues of concern or focus*</li> <li>Measure aligns with evidence-based or promising best practices</li> </ul>	<ul style="list-style-type: none"> <li>Lack of currency - measure no longer addresses issues of concern or focus*</li> <li><del>Measure does not usefully assess quality or cost-effectiveness</del></li> </ul>
Consistency with existing state and national quality measures, with room for innovation when needed	<ul style="list-style-type: none"> <li>Measure is nationally validated (e.g. NQF endorsed)</li> <li>Measure is a required reporting element in other federal, other state, or private health care quality or purchasing initiative</li> <li>National or other benchmarks exist for performance on this measure</li> </ul>	<ul style="list-style-type: none"> <li>Measure loses national endorsement</li> <li>Measure is unique to OHA when similar standard measures are available</li> </ul>
Attainability	<ul style="list-style-type: none"> <li>It is reasonable to expect improved performance on this measure (can move the meter)</li> </ul>	<ul style="list-style-type: none"> <li>CCO or entity performance is “topped out”</li> <li>Measure is too ambitious</li> </ul>
<del>Sensitivity</del> Accuracy	<ul style="list-style-type: none"> <li>Changes in CCO performance will be visible in the measure within reasonable time frame</li> <li>Measure usefully distinguishes between different levels of CCO performance</li> </ul>	<ul style="list-style-type: none"> <li>Measure is not sensitive enough to reflect capture improved performance</li> <li>Measure is not sensitive enough to reflect variation between CCOs</li> </ul>

Feasibility of measurement	<ul style="list-style-type: none"> <li>○ 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)</li> <li>○ Data collection for measure will be supported by upcoming HIT and HIE developments</li> </ul>	<ul style="list-style-type: none"> <li>○ Burden of data collection and reporting outweighs the measure's value</li> </ul>
Reasonable accountability	<ul style="list-style-type: none"> <li>○ CCO has some degree of control over the health practice or outcome captured in the measure</li> </ul>	<ul style="list-style-type: none"> <li>○ Measure reflects an area of practice or a health outcome over which CCO has little influence</li> </ul>
Range/diversity of measures	<ul style="list-style-type: none"> <li>○ Collectively, the set of CCO performance measures <del>should</del> covers the range of topics, health services, and populations of interest <del>to be provided by the organizations</del></li> <li><del>○ Measure provides valuable information about outcomes, quality, or efficiency of services in a given service area</del></li> </ul>	<ul style="list-style-type: none"> <li>○ There is a surplus of measures for a given service area or topic</li> <li>○ Measure is duplicative</li> <li>○ Measure is too specialized</li> </ul>

\* These issues include: 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.

## **Medicare – Medicaid Integration of Care and Services Work Group August 16, 2011 Meeting Summary**

### **Discussion Topics**

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The work group was divided into three smaller discussion groups to address the following questions and to identify the key points to go forward to the Oregon Health Policy Board:

- What successes have been achieved by Medicare and Medicaid in delivering services to individuals enrolled in both programs? What challenges are there to providing person-centered care that is high quality and gets greatest value for the dollars we spend?
- What are the structural disconnects or misalignments of incentives in the Medicare and Medicaid health and long term care and services systems that lead to inappropriate, expensive, or poor quality services for people? Are there ways we can change the incentives or rules so that everyone in the delivery system is pulling together and accountable for providing efficient, high quality care across all pieces of the system?

### **Key Points for Oregon Health Policy Board**

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- The delivery system must provide person-centered care with beneficiaries empowered and supported to access services and to direct and participate in their own care.
  - Importance of providing a broad range of services and supports, as well as a system that is easy to use or understand so people can get what they need, when they need it.
  - Individuals must be empowered and supported to be involved in their own care.
- The delivery system needs to be sensitive to beneficiaries with particular needs; in particular it needs to be more sensitive to disability issues.
- An improved delivery system needs to be built locally and will be dependent on strong relationships and collaboration, but the state needs to provide support and appropriate incentive structure so that good solutions can be brought to scale and sustained.
  - Oregon’s Medicare and Medicaid programs have been successful in many regards, but often the successes are localized and short-lived. These types of successes need to become statewide.
  - Communities will build unique systems for improving care and services bottom-up by bringing everyone to the table (but those local systems will not be scalable or sustainable without a top-down structure that supports and indeed requires everyone to take responsibility).
- There needs to be increased communication and collaboration among components of the health and long-term care systems, including components that will not be included in the global budget.
  - There is need for increased communications and collaboration between medical and long term care systems.

- There needs to be improved communication among providers and community partners in support of a holistic care model, including providers outside of the global budget.
- The challenge is to meet people's needs in a coordinated way with all systems (e.g., physical health, mental health, etc) working together.
- Communication and relationships are vital to an effective system, and electronic tools are part of the solution.

### **Small Group Discussion**

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#### ***Successes of Medicare and Medicaid in delivering services to individuals enrolled in both programs***

##### Program coverage successes:

- Increased health care access through coverage
- When OHP covered dental, dental care organizations provided care that greatly reduced the incidence of abscesses and other dental emergencies that the acute care system has to address
- Prioritized list works to direct resources where they can have most impact
- Individuals enrolled in both programs get Medicare covered services at no cost, even if the services are below the line in OHP

##### Long-term care:

- Long-term care entities do a lot of non-medical and preventive care that prevents the need for more acute care services.
- The Home and Community Base Care System (HCBS) delivery system is strong
- Long-term care is person-centered and has used the intra-disciplinary team concept with the person at the center

##### Provider and facility performance and innovation:

- Low nursing facility utilization compared with other states
- Low nursing facility length of stay compared with other states
- Good quality care by individual providers at the local level
- Health care providers who do home visits and intensive case management that keeps people out of the hospital (both physical health and mental health).

##### Integration:

- Eligibility workers can help get people into both Medicare and Medicaid managed care plans operated by the same organization.
- Integrated array of services both Medicaid and non-Medicaid from the same agency like Area Agencies on Aging.

- PACE provides an integrated model of care that provides people with what they need and has great outcomes.
- Fully-Capitated Health Plans (FCHPs) became Medicare Advantage plans to continue to coordinate medications with physical health.
- Oregon is way ahead of the curve with its collaboration, nationally.

Community linkages:

- Broad continuum of community based care
- Programs to keep people at home and employed

Other:

- Some providers are using health information technology in a unified way which also helps with metrics.

***Challenges to providing high quality care and services to beneficiaries in the two programs:***

Issues of coverage and access:

- Health providers are paid only when the person is sick; there is no bonus for wellness.
- Homelessness and lack of affordable housing. Need more integration of housing and services.
- Lack of peer wellness specialists/health navigators
- Shortage of in-home services and rules that preclude payment of some services delivered in the home and require patients to come to the provider offices or live in nursing homes to get services
- Addressing social determinants of health is outside the scope for systems of health care

Lack of person-centeredness and empowerment:

- People using services aren't empowered.
- Difficulty of holding health systems accountable for wellness with the reality of dealing with people who won't/can't take the steps to be healthy.
- Communication around care needs often does not include the patient
- The payer dictates the course of treatment and not the practitioner or patient

Failures to link systems or use what we have:

- Medical and long-term care systems collect a lot of data but they are not connected or used to improve patient care.
- Special Needs Plans are required to develop Health Risk Assessments but it's not clear how assessments are used.

Other:

- Stigma of behavioral health especially among seniors and primary care physicians

- None of this will work without more primary care providers; but if the healthcare delivery system restructuring results in cost efficiencies that can be used to fund primary care, that may help.
- Home care workers currently don't have the skills to provide a needed benefit in the health care system.
- Inconsistencies in the use of language.
- Difficulty of increasing patient accountability
- Pharmacy costs in Medicare are high
- Inadequate medication utilization review
- Families may not contribute toward Medicaid cost of care.
- There needs to be an expansion of palliative care and early advance care planning.
- There are fragmented transitions of care. There has to be at least better communication.
- We need culturally competent care that addresses everyone's needs.
- We need qualified people doing the work – at the top of their scope of practice; insufficient workforce development; insufficient numbers of primary care.
- There needs to be accountability for all providers. In the real world if the product is defective, you return it. That doesn't happen in the health care system.
- There is a need for better defined provider roles and responsibilities that allow community integrated models
- Rural issues – There are insufficient providers. Qualified people need to be incentivized to work there; need to expand the types of workforce (expand the role of the Home Care Worker); need to use more telemedicine.

***Structural disconnects and misalignments between Medicare and Medicaid that interfere with providing integrated, coordinated care:***

Program coverage rules:

- No payment is available for a physician to consult with a patient's family by phone.
- Medicare requires a 3-day hospitalization/admission to get Skilled Nursing Facility (SNF) admission, but sometimes individuals are admitted to or detained in the hospital just so that Medicare will cover nursing home care.
- Lack of OHP coverage for conditions that may be critical to the overall health of an individual, e.g. the Prioritized List of Health Services funding line.

Separation of funding streams and delivery systems:

- People have multiple problems but their problems are addressed by entities paid for by separate funding streams. Blended funding streams are necessary.

- Chemical dependency and mental health services are separately paid for and delivered.
- Public health is separate although it needs to be everyone's job.

Payment incentive issues:

- Hospital visits may be driven by the fact that there is better physician reimbursement when a (long-term care) patient is seen in the emergency department or as a hospital inpatient when the physician consults with a long-term care facility or visits a patient there
- There can be a disincentive to let people out of nursing facilities who could live in a less restrictive and less costly environment because providers want to avoid turnover and vacant beds

Poor incentives and structural issues that undercut efforts to coordinate:

- Mental Health drug carve out
- Medicare reimbursement rates for behavioral health are so low that access is a challenge
- Office visits with primary care providers are too short to really surface and address the multiple problems that many people enrolled in both Medicare and Medicaid have

Differences in Medicare and Medicaid rules that create confusion and gaps:

- DME –There are different criteria between Medicaid and Medicare. Also, there is fragmentation between vendors and physicians.
- Medicare requires behavioral health services be provided by licensed providers, interfering with access difficult although there are good non-licensed Medicaid authorized providers working certified by Addictions and Mental Health
- Inconsistent definitions between Medicare and Medicaid and their impact on OARs and services
- Duplicate HEDIS reporting requirements appear to be unnecessary as the time and money spent on reporting could be going to provide care

***Are there ways we can change the incentives or rules so that everyone in the delivery system is pulling together and accountable for providing efficient, high quality care across all parts of the system?***

- CCOs with global budgets for providing the full continuum of services have potential to break down silos and reduce counterproductive incentives, although forming a workable structure will be challenging.
- There is a need to design programs around specific disease states with a risk adjusted reimbursement methodology rather than a flat rate model
- Engaging physical and occupational therapists in a more holistic care model
- Community based solutions are needed as opposed to a one-size fits all model

- Integration of dental and mental health services into a new model. Intuitively this should lead to a reduction in other high dollar services
- The inclusion of requirements for health advocates or mentors for beneficiaries to support their need to become more health literate in order to become more self directed in their care
- Adjusting rates to attract providers to geographically underserved areas

***Key things work group members hope to improve as an outcome of this process:***

- There is a seamless system from the beneficiary perspective that is sensitive enough to meet people's needs.
- There is increased access to social supports.
- There is increased sensitivity to disability issues.
- There is more patient involvement & accountability.
- The broader system learns from the PACE model.
- The skill of home care workers is increased and the role enhanced so they can be part of the solution.
- Care in long-term care settings is more coordinated and higher quality.
- Insurance companies change to deal with people with all level of needs: those without homes, those with mental health issues, etc.
- Physical health, mental health, addiction, and oral health services are integrated.
- Behavioral health and primary care are integrated.
- Care is better coordinated so people get what they need, when they need it with fewer places to go and less confusion and fewer crises occur because people don't know how to get what they need: Right now, "individual providers are very good at turning the nut," but they do not work together to deliver good outcomes for people.
- There is greater use of peer wellness specialists.
- People are able to stay in their own home as long as possible.
- Medication use is more appropriate with better adherence and improved pain management.
- We are able to overcome reimbursement incentives that make it difficult to get people what they need. Reimbursement is based on outcomes rather than current conditions.
- The system is more prevention-focused.
- We better integrate technology for all health professionals involved in a person's care.

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# Oregon Health Policy Board Products

In support of health system transformation in Oregon, OHPB will deliver the following products to the Legislature in February 2011:

- Draft legislative language for implementation of Coordinated Care Organizations (CCOs)
- A business plan for CCO development
- Medical liability/cost containment strategies
- Standards for specified health care workers: community health workers, peer wellness specialists, personal health navigators

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# Elements of a Business Plan for Oregon Health System Transformation

HB 3650 directly requires that OHA and OHPB address the following issues, which will be elements in the business plan:

- Coordinated Care Organization (CCO) qualification process and criteria
- Global budget methodology
- Savings models and financial reporting requirements
- Health equity and health disparity strategies
- Plans for contracting with PEBB/OEBB and other public health benefit purchasers
- Outcomes, quality and efficiency metrics
- Coordination of care for individuals who are dually eligible for Medicare and Medicaid
- Transition to CCOs
- Alternative dispute resolution

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## CCO Criteria and Process

- **What is the direction of HB 3650?**

Section 4: See attached matrix

Section 13:

- (2) Using a meaningful public process, the Oregon Health Authority shall develop:  
Qualification criteria for coordinated care organizations in accordance with section 4 of this 2011 Act;

- **Product**

Business plan: Process outline and criteria matrix

- **Board's substantive recommendation**

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## Global budget methodology

- **What is the direction of HB 3650?**

Section 13:

(2) Using a meaningful public process, the Oregon Health Authority shall develop:

(a) ....

(b) A global budgeting process for determining payments to coordinated care organizations and for revising required outcomes with any changes to global budgets;

- **Product**

Business plan: global budget methodology

- **Board's substantive recommendation**

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## Financial reporting requirements

- **What is the direction of HB 3650?**

Section 13:

- (2) Using a meaningful public process, the Oregon Health Authority shall develop:
  - (d) A process that allows a coordinated care organization to file financial reports with only one regulatory agency and does not require a coordinated care organization to report information described in ORS 414.725 (1)(c) to both the authority and the Department of Consumer and Business Services; and
  - (e) ...
- (3) The authority, in consultation with the Department of Consumer and Business Services, shall develop a proposal for the financial reporting requirements for coordinated care organizations 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: ...

- **Product**

Business Plan: Financial reporting requirements

- **Board's substantive recommendation**

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## Financial Savings Models

- **What is the direction of HB 3650?**

Section 13:

(7) The authority shall prepare financial models and analyses to demonstrate the feasibility of a coordinated care organization being able to realize health care cost savings.

- **Product**

Business plan: financial savings modeling

- **Board's substantive recommendation**

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## Health Equity

- **What is the direction of HB 3650?**

Section 1: Legislative Intent

(b) Health care services, other than Medicaid-funded long term care services, are delivered through coordinated care contracts that use alternative payment methodologies to focus on prevention, **improving health equity and reducing health disparities**, utilizing patient centered primary care homes, evidence-based practices and health information technology to improve health and health care...

(d) Communities and regions are accountable for improving the health of their communities and regions, **reducing avoidable health gaps among different cultural groups** and managing health care resources

Further, the Health Authority is directed to regularly report the Governor and Legislature on progress toward eliminating health disparities *[Section 2(3)(b)]*

- **Product**

Business plan: Criteria and metrics

- **Board's substantive recommendation**

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## Medical liability/Cost Containment

- **What is the direction of HB 3650?**

Section 16:

(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:

- **Product**

Business plan element

Recommendation for legislative and administrative approaches

Potential legislative concept as necessary

- **Board's substantive recommendation**

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## Contracting with other public health benefit purchasers

- **What is the direction of HB 3650?**

Section 13:

(e) Plans for contracts with coordinated care organizations for other public health benefit purchasers, including the private health option under ORS 414.826, the Public Employees' Benefit Board and the Oregon Educators Benefit Board.

- **Product**

Business plan: PEBB/OEBB Board's work plan and timelines

- **Board's substantive recommendation**

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## Outcomes, quality and efficiency metrics

- **What is the direction of 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 coordinated care organizations. The authority shall incorporate these measures into coordinated care organization contracts to hold the organizations accountable for performance and customer satisfaction requirements.
- (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.
- (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.

- **Product**

Business plan: Principles, dimensions

- **Board's substantive recommendation**

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## Transition to CCOs

- **What is the direction of HB 3650?**

- (1) Notwithstanding ORS 414.725 and 414.737, in any area of the state where a coordinated care organization has not been certified, the Oregon Health Authority shall continue to contract with one or more prepaid managed care health services organizations, as defined in ORS 414.736, that serve the area and that are in compliance with contractual obligations owed to the state or local government.
- (2) Prepaid managed care health services organizations contracting with the authority under this section are subject to the applicable requirements for, and are permitted to exercise the rights of, coordinated care organizations under sections 4, 6, 8, 10 and 12 of this 2011 Act and ORS 414.153, 414.712, 414.725, 414.728, 414.743, 414.746, 414.760, 416.510 to 416.610, 441.094, 442.464, 655.515, 659.830 and 743.847.
- (3) The authority may amend contracts that are in place on the effective date of this 2011 Act to allow prepaid managed care health services organizations that meet the criteria approved by the Legislative Assembly under section 13 of this 2011 Act to become coordinated care organizations.
- (4) The authority shall continue to renew the contracts of prepaid managed care health services organizations that have a contract with the authority on the effective date of this 2011 Act until the earlier of the date the prepaid managed care health services organization becomes a coordinated care organization or July 1, 2014. Contracts with prepaid managed care health services organizations must terminate no later than July 1, 2017.
- (5) The authority shall 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 coordinated care organization but no later than July 1, 2013.

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## Transition to CCOs (continued)

- **Product**  
Business plan: Transition outline
  
- **Board's substantive recommendation**

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## Coordination of care and services for people who are dually eligible for Medicaid and Medicare

- **What is the direction of HB 3650?**

Section 21: *[OHA may...]*

- (2) Enter into agreements with, join with or accept grants from, the federal government for cooperative research and demonstration projects for public welfare purposes, including, but not limited to, any project *for*:
  - (a) Providing medical assistance to *individuals who are* dually eligible for Medicare and Medicaid using alternative payment methodologies or integrated and coordinated health care and services; or
  - (b) Evaluating service delivery systems.

- **Product**

Business plan

Design contract with CMS

- **Board's substantive recommendation**

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## Standards for specified health care workers: community health workers, peer wellness specialists, personal health navigators

### •What is the direction of HB 3650?

SECTION 11. Standards for health care workers. (1) The Oregon Health Authority, in consultation with the appropriate health professional regulatory boards as defined in ORS 676.160 and advocacy groups, shall develop and establish with respect to community health workers, personal health navigators, peer wellness specialists and other health care workers who are not regulated or certified by this state:

(a) The criteria and descriptions of such individuals that may be utilized by coordinated care organizations; and

(b) Education and training requirements for such individuals.

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

(a) Must be broad enough to encompass the potential unique needs of any coordinated care organization;

(b)(b) Must meet requirements of the Centers for Medicare and Medicaid Services to qualify for federal financial participation; and

(c) May not require certification by the Home Care Commission.

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## Standards for specified health care workers: community health workers, peer wellness specialists, personal health navigators

- **Product**  
Standards; education and training requirements
- **Board's substantive recommendation**

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# Alternative dispute resolution (ADR)

- **What is the direction of HB 3650?**

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.

(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.

- **Product**

Business Plan: ADR process outline

- **Board's substantive recommendation**

CCO Qualifications

Criteria <i>HB 3650</i>	Initial Baseline Expectations	Transformational Competencies	Examples of Accountability Metrics
Each member receives integrated person-centered care and services designed to provide choice, independence and dignity			
Health care services...focus on...improving health equity and reducing health disparities			
Each member has a consistent and stable relationship with a care team that is responsible for comprehensive care management and service delivery	x% of network are primary care health homes	x% of members are assigned to a team X% of primary care network are Tier 3 primary care health homes by year 3	% of members in a primary care health home % of primary care network certified as Tier 3
<b><i>CCO operates in a manner that encourages patient engagement, activation and accountability for their own health.</i></b>			
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	X% of members receive health screen in year 1 X% of high risk members have individualized care plan in year 1		
Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long term care setting			Follow-up after hospitalization: % discharged who have a primary care visit within 30 days % discharged with a mental health diagnosis who have follow-up in 7, and 30 days
Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health care interpreters, community health workers and personal health navigators who meet competency standards established by the Authority			
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			

Criteria <i>HB 3650</i>	Initial Baseline Expectations	Transformational Competencies	Examples of Accountability Metrics
Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable			
Each CCO complies with safeguards for members as described in Section 8, Consumer and Provider Protections, of HB 3650			
Each CCO convenes a community advisory council 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	Community advisory council established.		Attestation
Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services to reduce the use of avoidable ED visits and hospital admissions	All members receive health screen X% of high risk members have individualized care plan		% avoidable hospitalizations Measures of patient engagement or patient activation
<p>Members have <b>access</b> to a choice of providers within the CCO's network and that providers in the network:</p> <ul style="list-style-type: none"> <li>-work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members</li> <li>- are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history</li> <li>- emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication</li> <li>-are permitted to participate in networks of multiple CCOs</li> <li>-include providers of specialty care</li> <li>-are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards</li> <li>-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</li> </ul>			

Criteria <i>HB 3650</i>	Initial Baseline Expectations	Transformational Competencies	Examples of Accountability Metrics
Each CCO reports on outcome and quality measures identified by the Authority under Section 10 and participates in the All Payer All Claims data reporting system			
<i>Is transparent in reporting progress and outcomes.</i>			
Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks			
Each CCO participates in the learning collaborative described in ORS 442.210	Membership in learning collaborative		Attestation
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			
The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.			
On or before 7/1/14, each CCO must have a formal contractual relationship with any DCO that services members of the CCO in the area where they reside			
OHA shall encourage 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			

Criteria <i>HB 3650</i>	Initial Baseline Expectations	Transformational Competencies	Examples of Accountability Metrics
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.	x% of network are primary care health homes by end of year 1	x% of members are assigned to a team X% of primary care network are Tier 3 primary care health homes by year 3	% of members in a primary care health home % of primary care network certified as Tier 3

Highlighted rows indicate topics to be addressed by work group  
*Items in bold italics were identified as additional important criteria at first CCO Criteria work group meeting.*