

Health Systems Transformation Team

AGENDA

Wednesday, March 23, 2011

Willamette University

Putnam University Center, Cafeteria

6:00 pm to 7:30 pm

Public listen-only conference line – Dial: 877-455-8688, Participant code: 915042

#	Time	Item	Presenter
1	6:00	Welcome and agenda review	Bruce Goldberg Mike Bonetto
2	6:05	Governor Kitzhaber remarks	
3	6:20	Review of transformation straw person proposal	Bruce Goldberg Mike Bonetto
4	6:45	Issues of federal and state flexibility	Linda Grimms, Lead Council Judy Mohr Peterson, Director, Medical Assistance Program
5	7:00	Timeline review	Bruce Goldberg, Mike Bonetto
6	7:15	Wrap up, closing comments	Bruce Goldberg, Mike Bonetto
7	7:30	Adjourn	Bruce Goldberg, Mike Bonetto

**Health System Transformation Team
Minutes
March 16, 2011
Cherry Avenue Training Center
3414 Cherry Avenue, Suite 150
Mt. Mazama Room
6:00 PM to 9:00 PM**

Item
Welcome and agenda review (6:05 PM)
Review of feedback on definition and scope of Accountable Care Organizations Diana Bianco reviewed the feedback from the previous week on the name, definition, and scope of Accountable Care Organizations. Major issues included geography (what can we do to make this works statewide?), governance (how can we ensure accountability? How do we make sure it is community driven?), and consumer concerns.
Timeline; Response to comments on draft LC. Per the discussions and requests from the previous week's meeting, staff created three documents for today: a Health System Transformation Timeline through January 1, 2013; a Strawperson summary of Coordinated Care Organizations; and a document of approaches to the issues raised in comments on the draft legislative concept. All three documents can be found here . Bruce Goldberg and Mike Bonetto went over the documents and entertained questions and comments.
Small group break out: Next steps in LC development Groups discussed the Timeline and the Straw Person.
Report out and large group discussion Diana Bianco facilitated the large group discussion: the Team heard from a speaker from each break out group. Comments covered issues regarding both the Timeline and the Strawperson, including consumer choice, global budget, questions about specificity around early adopters, metrics, timeline aggressiveness, and community technical assistance/education.
March 23 agenda Waivers; final comments on today's Strawperson; wrap up.
Adjourn (8:58 PM)

Next meeting:

**March 23, 2011
Willamette University,
Putnam University Center.
6:00 to 9:00 pm**

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Coordinated Care Organization (CCO)

Definition

- CCO means an organization that serves as a single-point of accountability for the cost of health care within a global budget and for access to and quality of a coordinated system of physical health, behavioral health and oral health care services delivered to the specific population of patients enrolled with the organization.
- A CCO is also responsible for managing health care for persons in long-term care as part of an overall treatment plan.
- A CCO is a local, community-based organization or a statewide organization with community-based participation in governance. A CCO may be a single corporate structure or a network of providers organized through contractual relationships.

Populations

- A CCO will be accountable for the health care of its members, including serving members who are dually-eligible for Medicare and Medicaid. Oregon's Medicaid program will serve as an early demonstration of a health care delivery system based on CCOs;
- The goal is that all Medicaid clients in the state will be enrolled with a CCO as rapidly as possible.
- Begin a formal process to examine how to best extend this model to public employees and other commercial populations.

Governance

- Governance needs to reflect the responsibility for risk, the major components of the health care delivery system, and the community at large. Flexibility is needed to address the operational needs of the CCO, while remaining accountable to community values and population health needs.
- Because counties are the local mental health and public health authorities, CCOs must have a formal, contractual relationship with the county or counties in which they operate.
- Consumers must have a role in governance of the CCO.
- CCOs will establish Community Advisory Committees to ensure that the needs of consumers and the community are being addressed; the membership would include county representation.
- Specific mechanisms will not be outlined in statute, but CCO decision-making will meet policy objectives identified in statute and reflect input from:
 - Consumers including seniors, people with disabilities, people using behavioral health services, and
 - Racially and ethnically diverse populations reflective of the CCO service area; and
 - Providers in the CCO

Coordinated Care Organization (CCO): Strawperson Summary

Geography and Size

- A CCO should be of sufficient size to effectively manage risk and address capacity and access issues. There will not be a specific designation of the number of CCOs or the number of service areas.
- Where appropriate in terms of systems of care and provider capacity, OHA may authorize through the RFP process more than one CCO in a given service area.
- The goal is to have all Medicaid members enrolled with a CCO as rapidly as possible; OHA will develop strategies in partnership with communities to ensure a smooth transition from the delivery system structures currently in place. *[Note: Still need to work out a process for areas of the state where the RFP process does not identify a qualified CCO]*

Integration and Scope

- CCOs are responsible for the full integration of physical, behavioral and oral health care services for the specific population of persons enrolled with the organization, including their members who are dually eligible for Medicaid and Medicare.
- The goal is to achieve optimal health outcomes. Medicaid services expected to be provided are those outlined by the Prioritized List of Health Services currently provided through existing contracts, which will be regularly updated based on the best evidence. Medicare services will comply with federal regulations and include those services provided in Medicare Parts A, B and D.
- A CCO will be responsible for the **health care** of members who are also in long term care. There is no intent for the management of long term care budgets to be part of the CCO.
- To allow for necessary integration and risk sharing, state and federal safe harbors should be requested that protect CCOs and providers from antitrust, Stark, anti-kickback and civil monetary penalty laws.
- To allow for effective integration and risk management, privacy laws need to permit CCOs to access essential individual-level data while protecting the privacy and security of its members.
- A CCO should prioritize working with CCO members with high needs and multiple chronic conditions, mental illness or chemical dependency to involve them in accessing and managing appropriate preventive, health, remedial and supportive care and services, and reducing the avoidable use of services provided in emergency rooms and hospital readmissions. Safeguards will be outlined in contract and rule to avoid risk selection practices.
- Individuals should receive comprehensive transitional care, including appropriate follow-up, when there is a change in care setting, including but not limited to entering and leaving inpatient hospital or nursing facility to other care settings or return to their home, or for a significant change in care providers.
- CCOs should develop and participate in Learning Collaboratives to ensure the sharing and implementation of best practices.

Coordinated Care Organization (CCO): Strawperson Summary

Provider Networks

- Providers may participate in the networks of multiple CCOs.
- CCOs should demonstrate excellence of operations including but not limited to network provider creation and management functions. They will use, to the maximum extent feasible, person-centered health homes and best practices in primary care, including developing capacity for services in settings that are accessible to families, diverse communities, and underserved populations. Specialty services must include access to statewide resources as needed.
- Members should have a choice of providers within the CCO's network.
- FQHCs, Rural Health Clinics (RHCs), School-Based Health Clinics and other safety net clinics should be supported to ensure their critical role in providing primary care and primary care home services for underserved populations.

Budget and Payment

- Global budget
 - A global budget means a total amount established prospectively by the state to be paid to a CCO to provide the full continuum of services for its population. Within its budget, the CCO is responsible for the cost of delivery, management, access and quality of care delivered to the people enrolled with the CCO.
 - OHA is required to establish a process to develop global budgets based on available revenue and on expected patterns of care after transformation of the finance and delivery system.
 - Global budgets will be developed with adequate risk adjustment mechanisms and other activities associated with analysis and monitoring of CCO utilization and cost data and other financial metrics. This will be done utilizing national and statewide expertise and include legislative input. Budgets will be established that grow at an established fixed rate. *[Note: Still need to establish mechanisms to ensure that mental health crisis system, medical education and other community needs are supported in the context of a global budget.]*
 - The global budget should be configured to hold CCOs accountable for outcomes.
 - In order that providers engage in long-term delivery system changes, mechanisms should be developed that ensure that as outcomes improve and service delivery is reconfigured, that savings are shared and that the CCO's provider payments are also reconfigured to reflect the system changes.
 - Risk adjustment mechanisms or risk mitigation strategies will be addressed in contract and rule.
- Payment:
 - CCOs are required to demonstrate how they will apply alternative payment methodologies that move from predominantly fee-for-service to alternate payment methods in order to base reimbursement on quality and value rather than volume of services and to realign incentives to support transformation policy objectives.
 - Restructured payments and incentives should reward comprehensive care coordination in new delivery models such as person-centered health homes.

Coordinated Care Organization (CCO): Strawperson Summary

- Shared savings:
 - CCOs are required to identify cost savings and coordinate the sharing of any overall achieved cost savings with the CCO providers and practitioners in a transparent manner that furthers the goals of the CCO to improve quality and accessibility while reducing costs of health care throughout the CCO service area.
 - A shared savings methodology will be developed to identify and capture Medicare dollars.

Consumer Protection and Accountability

- Consumer Protection:
 - Requirements for CCOs includes some provision for system navigation and for engaging the patient in their care and care planning:
 - Consumers must have access to competent advocates, including qualified peer wellness specialists where appropriate; system navigators; and qualified community health workers who are part of the care team to provide assistance that is culturally and linguistically appropriate to their needs to access appropriate services and participate in processes affecting their care/services.
 - Consumers will be encouraged within all aspects of the care and services system to use wellness and prevention resources, and to make healthy lifestyle choices.
 - Consumers are encouraged to work with their care teams, including providers and community resources appropriate to the consumer's needs as a whole person.
 - Consumers have the right to appeal decisions about their care and services, and to receive a timely response, within the CCO and with the Oregon Health Authority.
- Accountability:
 - An expert workgroup convened by the Oregon Health Policy Board will identify key outcomes and develop metrics to be included in the RFP, with an emphasis on the key priorities to improve value.
 - Detailed requirements for accountability and metrics will be addressed in contract and rule.
 - *Financial Accountability*—CCOs will need to demonstrate through specified financial reporting requirements excellence of operations, including best practices in financial management capabilities. Specific expectations regarding assessment of adequacy of reserves and solvency will need to be demonstrated by the CCOs and monitored by OHA.
 - *Community Accountability*—CCOs have **shared** accountability for the overall health of **members** in their area, and will need to work cooperatively and form relationships with community partners to address public health issues that affect the health of the community, including prioritizing health equity.
 - *Individual accountability*—A component of shared accountability resides with the individual members of a CCO. CCOs will develop, in collaboration and coordination with providers and OHA, strategies that encourage healthy behaviors and healthy lifestyles, prevention and wellness activities, developing skills in help-seeking behavior including self-management and illness management. Strategies include, but are not limited to incentive systems, patient education, and improved access to primary care and behavioral health services through patient-centered health homes, home-based services, and

Coordinated Care Organization (CCO): Strawperson Summary

telephone and web-based communication by culturally and linguistically appropriate means.

- *Quality of Care and Outcomes* – Quality metrics will include measures of quality for ambulatory care, inpatient care, behavioral health care and oral health care. Key quality metrics of interest, including health status, experience of care, and patient activation, will be evaluated on a regular and ongoing basis. Metrics will be stratified by key demographic variables including race and ethnicity. Quality metrics will be consistent with standard quality measures adopted by and reported to the Oregon Health Authority to evaluate value and population health.
- CCOs need to demonstrate how they are holding their provider networks accountable for the care delivered.

Transparency

- All members should have the information they need to make informed choices among CCOs and among providers. CCOs and OHA will ensure transparency of financial data, including payer and provider costs, provider payments; and outcomes, quality measures and other information necessary to discern the value of health care services; CCO's role is to submit appropriate data and information to OHA, and OHA role is to serve as data aggregator and reporter.
- As information and data collection systems improve, the intent is to move from demonstrating process metrics to outcomes metrics. The OHA will be responsible for developing or endorsing metrics that will evolve over time as capabilities for reporting improve.
- Better utilize available data systems for reporting and eliminate any redundant or reporting of limited value.

Implementation

- Administrative simplification and Regulatory Relief
 - To the extent allowable, regulatory and administrative requirements will be streamlined and consolidated, including federal standards, certification, and reporting.
- Federal Approvals
 - The Oregon Health Authority will be seeking federal approvals to establish global budgets, to blend Medicare and Medicaid funding for people who are dually-eligible for Medicare and Medicaid, to manage medical care more effectively across the full spectrum of service needs, and to pay differently for services and care. There may be additional areas that will also require exception from certain administrative requirements within federal Medicaid and Medicare rules.

Medical Liability

- Tort reform has been identified as a central component to health system transformation. Specific details around a proposal will need to be developed in order to move forward.

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Federal Flexibility and State Statutory Changes For Health System Transformation

For Oregon to implement Coordinated Care Organizations (CCO) in the Oregon Health Plan we will need to request flexibility from the federal Centers for Medicare and Medicaid Services (CMS); some changes will be required in state statute as well. This document identifies the major areas staff have identified that may require federal permission or changes in state law.

Federal flexibility

The Oregon Health Authority will seek federal approval for the following design components of Coordinated Care Organizations and Health System Transformation. This list is not comprehensive; as the Oregon legislature further develops the CCO concept additional areas may be identified where Oregon will need flexibility from CMS.

Global Budget. Capped total spending with strict year-over-year budget targets was identified as an essential element of an accountable organization. Establishing a global budget for each of the CCOs will require federal permission.

Global budgets will be pre-paid to a CCO to provide the full continuum of services for its population. Within its budget, the CCO is responsible for the cost of delivery, management and quality of care delivered to the people enrolled with the CCO. OHA will establish a process to develop global budgets and other activities associated with analysis and monitoring of CCO utilization and cost data and other financial metrics.

Integration and Scope. Oregon has the ability to accomplish some integration under its current authority, but a number of the Health System Transformation Team's innovations will require federal approval, specifically:

- Proposing to blend Medicare and Medicaid funding for people who are dually eligible for Medicare and Medicaid.
- Utilizing non-traditional personnel to deliver services, supports, and supplies not traditionally part of Medicaid. These services, supports and supplies should be included in the CCO global budget.
- Requesting safe harbor protection from antitrust, Stark, anti-kickback and Civil Monetary Penalty Laws to allow development creation and implementation of Coordinated Care Organizations and their well coordinated provider networks.

Consumer Protection. Strong consumer protections were also identified as an essential element of Coordinated Care Organizations. While federal law includes consumer protections, they are not necessarily aligned across Medicare and Medicaid. Oregon will ask to streamline and simplify due process rights such as complaints, appeals, and grievances including aligning Medicare and Medicaid while maintaining appropriate consumer protections.

Administrative simplification and Regulatory Relief. To the extent allowable, regulatory and administrative requirements will be streamlined in Oregon's delivery system redesign:

- Where regulatory and administrative requirements differ between Medicare and Medicaid, Oregon will ask to streamline and consolidate, including alignment of requirements for Quality Assurance and Performance Improvement; and
- Allow covered individuals to authorize the state and Coordinated Care Organizations to provide notices and informational materials via e-mail, text or other alternatives to mail.

Mandatory Enrollment and Churn: In order to maximize the potential value of integration and to minimize administrative costs associated with enrollment and disenrollment (churn), it will be important to maximize and stabilize enrollment in CCOs. Oregon will ask for federal flexibility to require:

- Mandatory enrollment in a CCO, with appropriate criteria for opting out; and
- Include individuals eligible for Medicare and Medicaid; and
- Require that individuals enroll in a CCO for a specified length of time, with appropriate criteria for changing CCOs.

Privacy: Current privacy laws for some special classes of diagnosis and treatment (e.g., substance abuse) act as barriers to the effective coordination of care. Oregon will request authority for CCO's to share patient identifiable information for the purposes of care coordination and treatment.

Operational Adjustments: Oregon will request the authority to make ongoing operational adjustments without first going through detailed federal approval processes.

Changes in State Law

In order to implement the Coordinated Care Organization system, state law changes will need to address:

Delivery system changes that are consistent with the new delivery system for coordinated care:

- For the medical assistance program, replacing the "prepaid managed health care" delivery system with the coordinated care organization delivery system
- Reshaping the health care delivery system to include a person-centered focus, accountability to community and consumer values, implement consumer protections, and other issues that have been developed with HSTT input
- Reforming payment methodologies that promote prevention and person-centered care, measure outcomes, and contain costs

Individuals eligible for both Medicare and Medicaid. Statute should provide explicit authority to include the health services for individuals who are dually eligible for Medicaid and Medicare within the new delivery system.

Operational components that will make coordinated care successful:

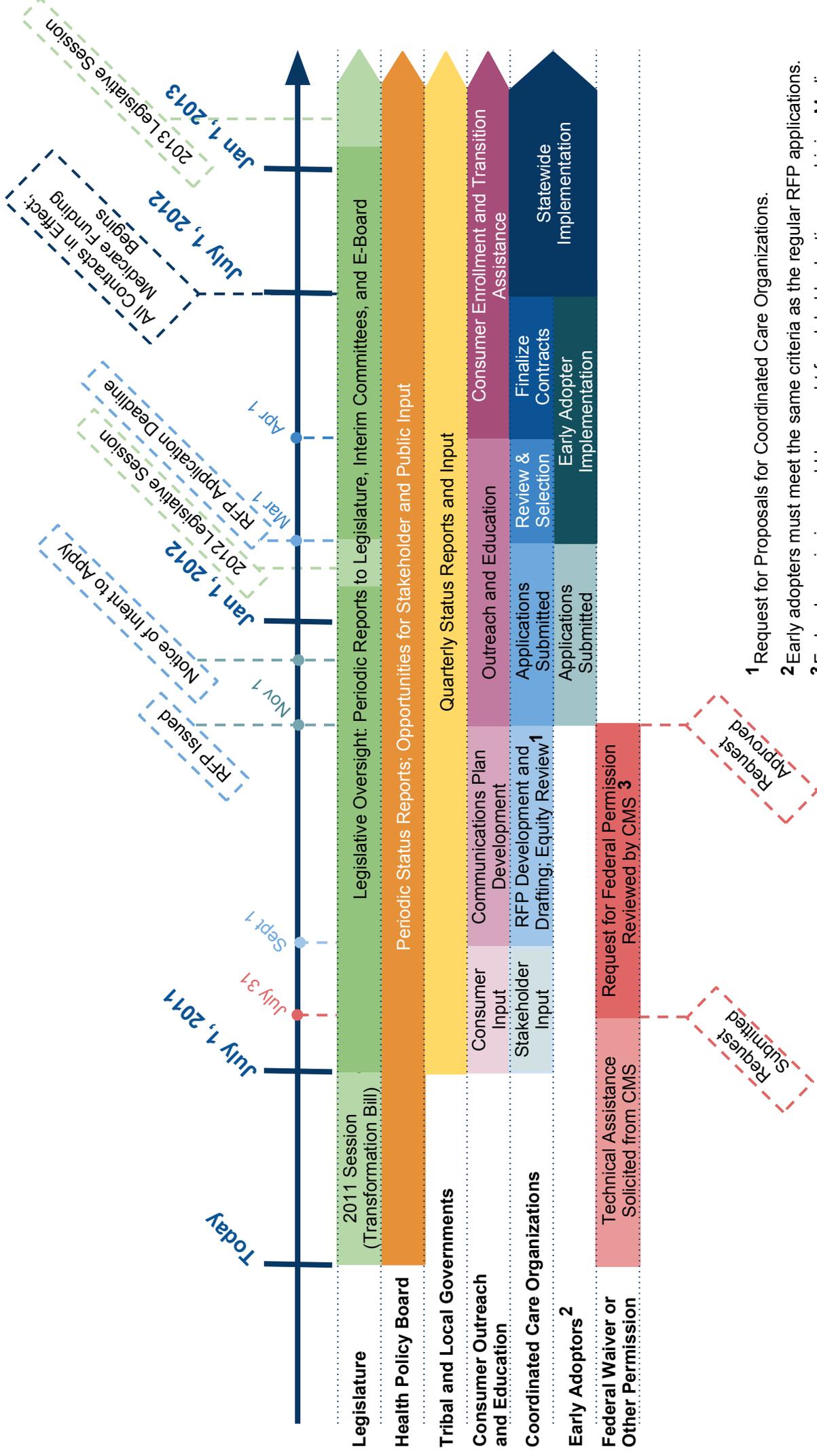
- Addressing state law barriers to information sharing by providers and the coordinated care organization;
- Requiring measures of quality of care and outcomes, and transparency, that inform decision making;
- Streamlining regulatory and administrative requirements imposed by state law.

Health System Transformation Team
 Budget savings options from 2/2/11 meeting

Options	Biennial savings estimate (GF)	Notes
<p>Eliminate payments for marginally effective treatments based on evidence: The last 39 items on the Prioritized List of Health Services are prioritized to the bottom of the list because they have been determined by evidence to be marginally effective.</p> <p>Estimates of eliminating payments for the least effective 5% of treatment for covered diagnoses</p>	<p>\$29m</p> <p>\$43m</p>	<p>Included in GBB</p> <p>Included in GBB as part of Transformation Savings. Likely overlaps some with elimination of payment for 39 lines on the Prioritized List of Health Services.</p>
<p>Eliminate payments for never-events and healthcare acquired conditions: Following Medicare definitions.</p>	<p>\$0.04m</p>	<p>Included in the GBB. This is a FFS estimate only. Capitation for MCOs already reflects “no pay” Medicare events.</p>
<p>Further restrict allowable DME– This could be a means for plans and other providers to reduce their costs.</p>		
<p>a. Add diabetic supplies to preferred drug list and allow pharmacists to dispense.</p> <p>b. Bulk purchasing of hearing aids</p> <p>c. Sole source contracts for 3 or 4 DME suppliers</p> <p>d. Reduce FFS DME rates for codes reduced by Medicare on 1/1/09</p>	<p>\$0.31m</p> <p>\$0.01m</p> <p>\$0.40m</p> <p>\$0.29m</p>	<p>a. Included in GBB</p>
<p>Restructure of dental benefit more to align with commercial benefit design to include limits on expenditures. This could be a means for dental plans to operate within their rate reductions.</p>	<p>\$1.5m</p>	<p>Limiting dental coverage to \$1750 per year yields an estimated \$1.5 million general funds and \$4 million total funds. This would limit dental for non-pregnant adults only.</p>
<p>Tighten restrictions on prescribing brand name drugs where good generic options are available.</p> <ul style="list-style-type: none"> • Make the Medicaid preferred drug list (PDL) enforceable, make mental health preferred drug list enforceable, limit utilization of 		<p>Generic prescribing is at about 80%-85% in Medicaid, so opportunity for savings is limited.</p>

Options	Biennial savings estimate (GF)	Notes
<p>non-preferred drugs.</p> <ul style="list-style-type: none"> Development of an enforceable statewide PDL 	<p>\$7m \$20m</p>	<p>In GBB Assumptions:</p> <ol style="list-style-type: none"> Mandate that MCOs must follow PDL Mandate that PEBB/OEBB follow PDL Allow OHA to look at cost of drugs, net of rebate across the entire OHA, not by individual program silo Specifically authorize OHA to join other states in negotiating rebates.
<p><i>Implement patient-centered primary care homes to enhance care coordination.</i></p>	<p>\$13m</p>	<p>In GBB as a Transformation Savings</p>
<p><i>Initiate broad use of DRG methodology for inpatient care, APCs for outpatient.</i></p>	<p>\$4.6m \$5.5m \$1.1m</p>	<p>DRG methodology (inpatient) in managed care APCs (outpatient hospital) in managed care APCs (outpatient hospital) in FFS</p>
<p><i>A new model of care for “open card”/FFS portion of OHP</i></p>	<p>\$58m</p>	<p>In GBB. Assuming 20% of GBB Transformation Savings comes from addressing inefficiencies in FFS. [FFS expenditures include services that are not currently included in managed care contracts (e.g., mental health drugs (15%); transportation services (8%), and individuals not enrolled or “enrollable”-- for instance, individuals in their 1st month of eligibility and not yet enrolled in managed care (2%); individuals in areas with no MCOs or MCOs at capacity (16%); Tribal members/dually-eligible individuals (9%).]</p>
<p>Total savings Identified by HSTT Total included in GBB Net savings not included in GBB</p>	<p>\$184m \$150m \$34m</p>	

DRAFT - HEALTH SYSTEM TRANSFORMATION TIMELINE



¹ Request for Proposals for Coordinated Care Organizations.

² Early adopters must meet the same criteria as the regular RFP applications.

³ Federal permission would be sought for global budgeting, combining Medicare funding for dual-eligibles beneficiaries with Medicaid, and payment reform.