Subject: Oregon Health Insurance Exchange Information and Update

Hello!

The Oregon Health Insurance Exchange website has a list of meeting dates, materials for upcoming meetings, and past meeting materials and audio/video. You can access this information at https://orhix.org/ .

Included is the Oregon Health Insurance Exchange Agenda and Board Packet for the Board of Directors meeting**,** which is happing today Friday, Dec. 16, 8 a.m.-Noon. The packet has the **Oregon Health Insurance Exchange Corporation Business Plan (draft).** This document lays out Oregon Exchange how Oregonians can compare their health coverage options and find out if they are eligible for financial assistance The next meeting is scheduled for January 11th, 2012 time and location TBA. Please sign up for ORHIX e-mail alerts and latest meeting announcements at info@orhix.org.

Also, included is Oregon Health Policy Board (OHPB), **draft CCO Implementation Proposal** that was released for public review. This document lays out the governance for Coordinated Care Organizations, the criteria to apply, details of how a global budget will work, and the methodology for the quality metrics that will hold CCOs accountable for better health. It is a lengthy document, please review and provide feedback on the proposal. Public comment is being accepted via email at OHPB.Info@state.or.us.

If you have any questions please feel free to contact Jim Roberts at jroberts@npaihb.org or by phone at 503.416.3276 or myself Lisa Griggs at lgriggs@npaihb.org or by phone at 503.416.3269.

Thanks,

Lisa L. Griggs {Blackfeet}
Northwest Portland Area Indian Health Board (NPAIHB)
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Agenda

Oregon Health Insurance Exchange Corporation
December 16, 2011

8:00am- 12:00pm
Legacy, Meridian Park
Education Building, Room 117
19300 SW 65th Avenue
Tualatin, OR 97062

Agenda Item	Presenter	Type of Item
8:00 **Welcome, Introductions, Agenda Overview** **Consent Agenda:** 11/22/11 Meeting Minutes	Chair	**Action**
8:10 **Director's Report**	Rocky King	**Inform**
8:20 **Business Plan Review**	Amy Fauver, Rocky King Steve Ferree	**Input**
10:20 **Break**		
10:35 **Business Plan: Public Input**		
10:55 **Exchange IT Project Overview**	Aaron Karjala	**Inform**
11:15 **Exchange Development Update**	Rocky King	**Inform**
11:55 **Public Input**	Chair	

Next Meeting:
January 11, 2012 (tentative)
Time and Location TBA

Minutes

Oregon Health Insurance Exchange Corporation Board of Directors Meeting
November 22, 2011

Meeting called to order: 1:27pm
Meeting adjourned: 5:07pm

Board Members Present: Ken L. Allen; Teri G. Andrews; Elizabeth "Liz" C. Baxter; George J. Brown, MD; Aelea Christofferson (via teleconference); Bruce Goldberg, MD; Jose B. Gonzales; Teresa D. Miller; Gretchen Peterson.

ORHIX Staff Present: Amy Fauver, Kelly Harms, Rocky King, Rachel Oh.

Others in Attendance: Diana Bianco, Steve Ferree, Lavinia Goto, Jon Jurevic, Jim Lussier.

AGENDA ITEMS	DISCUSSION
Consent Agenda	**Ms. Baxter moved to approve the minutes from the November 1, 2011 Board meeting. Ms. Christofferson seconded. Motion passed unanimously.**
Director's Report – *Rocky King*	Mr. King provided a staffing update, stating that Ms. Miller has accepted a job with the Washington D.C. entity charged with coordinating the rollout of health insurance exchanges nationwide under the Affordable Care Act (ACA). He reviewed contract status with Point B, an information technology (IT) firm that will help manage the overarching technology project in alignment with efforts of the Oregon Health Authority (OHA). Mr. King added that a contract with Quality Corporation (Q-Corp) is near finalization and that Q-Corp will help attain consistency in plan standards among various state agencies. Mr. King announced the availability of the new, temporary website for the Oregon Health Insurance Exchange (ORHIX), www.orhix.org. He reviewed collaborative work with the insurance division related to re-insurance and risk adjustment modeling and modeling the three risk adjustment programs using 2010 carrier data. This work will help prepare for future rate adjustments and is funded through the federal level one grant. Mr. King stated that he, Ms. Baxter and Ms. Andrews presented to the Joint Health Care Committee and various legislators and summarized those discussions. He stated that the recent Federal Gateway Review of our IT project went well and Oregon is viewed very favorably with regard to our progress. Mr. King reviewed the storyboarding process underway at the staff level and affirmed that the financial modeling necessary for the business plan is being carefully crafted using accurate ranges. He added that a legislative training session will soon be made available to the Board. He also reviewed the current work of

Director's Report – *(cont.)*	various internal work groups, consumer groups and community organizations. Mr. King stated that a finalized contract with Sandstrom Partners (Sandstrom) will be provided to the Board soon and members are encouraged to ask questions regarding the communications plan Sandstrom will be developing. Mr. Goldberg asked why the Board hasn't seen other contracts mentioned earlier and Mr. King explained that only contracts over $250k require Board review, as per the ORHIX bylaws. Ms. Christofferson asked how much would be spent with Sandstrom prior to final legislative decisions. Mr. King stated that no project work is being held back pending legislative approval. Ms. Baxter asked how much the Board will learn from the various work groups and Mr. King said that for now, these groups operate on the technical level with staff and that, in spring 2012, the results of this activity will be formally reported to the Board.
Consumer Advisory Committee – *Steve Ferree, Rachel Oh*	Ms. Oh introduced Mr. Ferree as the Vice Chair of the Consumer Advisory Committee (CAC). Mr. Ferree summarized the diversity and synergy of this 22-member Committee and noted the effectiveness of their work together. Ms. Baxter encouraged all Board members to join a future meeting to observe and appreciate the energy and effectiveness of this group.
Mission & Vision – *Diana Bianco*	Ms. Bianco reviewed discussion of the mission and vision and progress made since the November 1, 2011 Board retreat. Ms. Bianco opened the floor to Board comments. The Board agreed upon various revisions to the mission statement and further agreed to postpone additional work on the vision statement. Ms. Andrews moved to approve the following Mission Statement: "Improving the health of all Oregonians by providing coverage options, increasing access to information, and fostering quality and value in the healthcare system." Mr. Allen seconded. Motion passed unanimously.
Ends Discussion –*Diana Bianco, Jim Lussier*	Ms. Bianco reviewed work to-date on the ends statements that are designed as anchors for the Board's work. Mr. Lussier discussed the process of measuring progress against the ends statements. The Board reviewed the statements, which are intended to be aspirational in nature. Ms. Bianco and Mr. Lussier committed to working with staff to further refine the Ends Statements and return their work to the Board as part of the draft policy manual.
Policy Manual Update – *Diana Bianco*	Ms. Bianco reviewed changes made to the manual draft since the November Board retreat and led discussions on areas needing further discussion and refinement.
Business Plan and CAC Input – *Steve Ferree, Kelly Harms, Jon Jurevic, Rocky King*	Ms. Oh reviewed discussions held at the last Consumer Advisory Committee meeting and stated that two themes came to light; the exchanges as a single source of trusted information with the goal of simplifying the consumer experience and that the exchange should be proactive. She summarized discussions about agents

Business Plan and CAC Input – *(cont.)*	and navigators and potential training opportunities. Ms. Andrews asked for clarification on the role of a navigator and Ms. Oh stated that a navigator can be an agent but doesn't have to be licensed, and is envisioned to function more as a client services representative. Mr. King stated that the Business Plan ("the Plan") in its current form should be considered a template versus a final version and that a revised, populated version would be delivered to the Board in early December. Mr. King introduced Mr. Jurevic as the ORHIX Interim Chief Financial Officer. Mr. Jurevic summarized his view of managing projections within a start-up environment and discussed the projections and assumptions contained within the Plan. Mr. King summarized how administrative costs will be met through the end of 2014 and ORHIX's ability to place assessments into a capital fund to build a six-month reserve fund for use in 2015. Mr. Jurevic emphasized that the cost of IT will be the biggest challenge to anticipate due to need for continued refinement and cost of professional talent engagement. Mr. King reviewed anticipated enrollment rates and the impact on call center demand, and summarized the Gruber projection, adding that ORHIX is preparing projections at the estimated low, medium and high levels. Ms. Baxter asked what is required of Board members after they receive an update to the Plan and Mr. King asked the Board to review the Plan with three questions in mind: does the Plan explain who we are, what we do, and what these activities will cost. Ms. Peterson asked how much content from the Plan is being provided to legislators in advance and Mr. King explained that legislators have access to the same content as has been provided to the Board. The Board discussed the legislative approval process and timeline and outlined plans for additional review and eventual approval of the Plan prior to the February 2012 legislative session.
Public Comment – *open forum*	

Next Board Meeting:
December 16, 2011
Legacy, Meridian Park
Education Building, Room 117
19300 SW 65th Avenue
Tualatin, OR 97062
8:00am- 12:00pm

Oregon Health Insurance Exchange Corporation

Business Plan

February 2012

Draft December 9, 2011

Oregon Health Insurance Exchange Corporation
3414 Cherry Ave. N.E., Suite 190
Salem, OR 97303
www.orhix.org

Table of Contents

Executive Summary

PLACEHOLDER

Overview of the Oregon Health Insurance Exchange

Our Mission: Improving the health of all Oregonians by providing health coverage options, increasing access to information, and fostering quality and value in the health care system.

The Oregon Health Insurance Exchange is a central marketplace where consumers and small businesses can shop for health insurance plans and access federal tax credits to help them pay for coverage. Oregonians will be able to easily compare plans, find out if they are eligible for tax credits and other financial assistance, and enroll for health coverage through the Exchange website. They also will be able to shop and enroll by calling a toll-free number and working with community-based navigators and agents.

Value of the Exchange

The Oregon Health Exchange Corporation will fulfill its mission by providing the following services to Oregonians and businesses.

- **Central place to shop for insurance plans.** The Exchange will provide easy-to-compare information on health plan quality and price.
- **Reliable information and assistance.** The Exchange will provide information on how to best use health benefits to improve health as well as referrals to other resources if appropriate.
- **Focus on cost and value.** The Exchange can help control the underlying cost drivers in health care through the standards it sets for plans sold in the Exchange. This work will be done in concert with Oregon's other health transformation efforts.
- **Seamless eligibility and enrollment process.** With a single application, Oregonians can find and enroll in the health plan that best meets their needs.
- **Help paying for health coverage.** More Oregonians will be insured, with the help of federal tax credits or other assistance available through the Exchange that makes health care coverage more affordable.
- **Innovative plan options and simplified plan administration for small businesses.** Small business can allow their employees to choose an insurance company and plan through a defined contribution model.
- **Community-based assistance.** The Exchange will include a network of specially trained customer service staff, navigators, insurance agents, and other community-based organizations that will help guide Oregonians in all parts of the state through applying to the Exchange and enrolling in coverage.

Road to Oregon's Exchange

Oregon has been exploring the concept of a health insurance exchange for the past decade. A series of legislative acts, starting in 2007, culminated in the passage of Senate Bill 99, signed into law on June 22, 2011.

The *Patient Protection and Affordable Care Act,* signed into law in March 2010, requires all states to operate a health insurance exchange by January 1, 2014. States developing exchanges must receive readiness certification from the federal government in January 2013.

If states do not operate their own exchanges, the federal government will implement an exchange for them. By developing its own exchange, Oregon can ensure it meets the unique needs of the state's consumers, businesses, and health insurance market. It also gives Oregon the ability to be innovative in the design of plans offered through the Exchange, so it can better contribute to broader state health reforms under way.

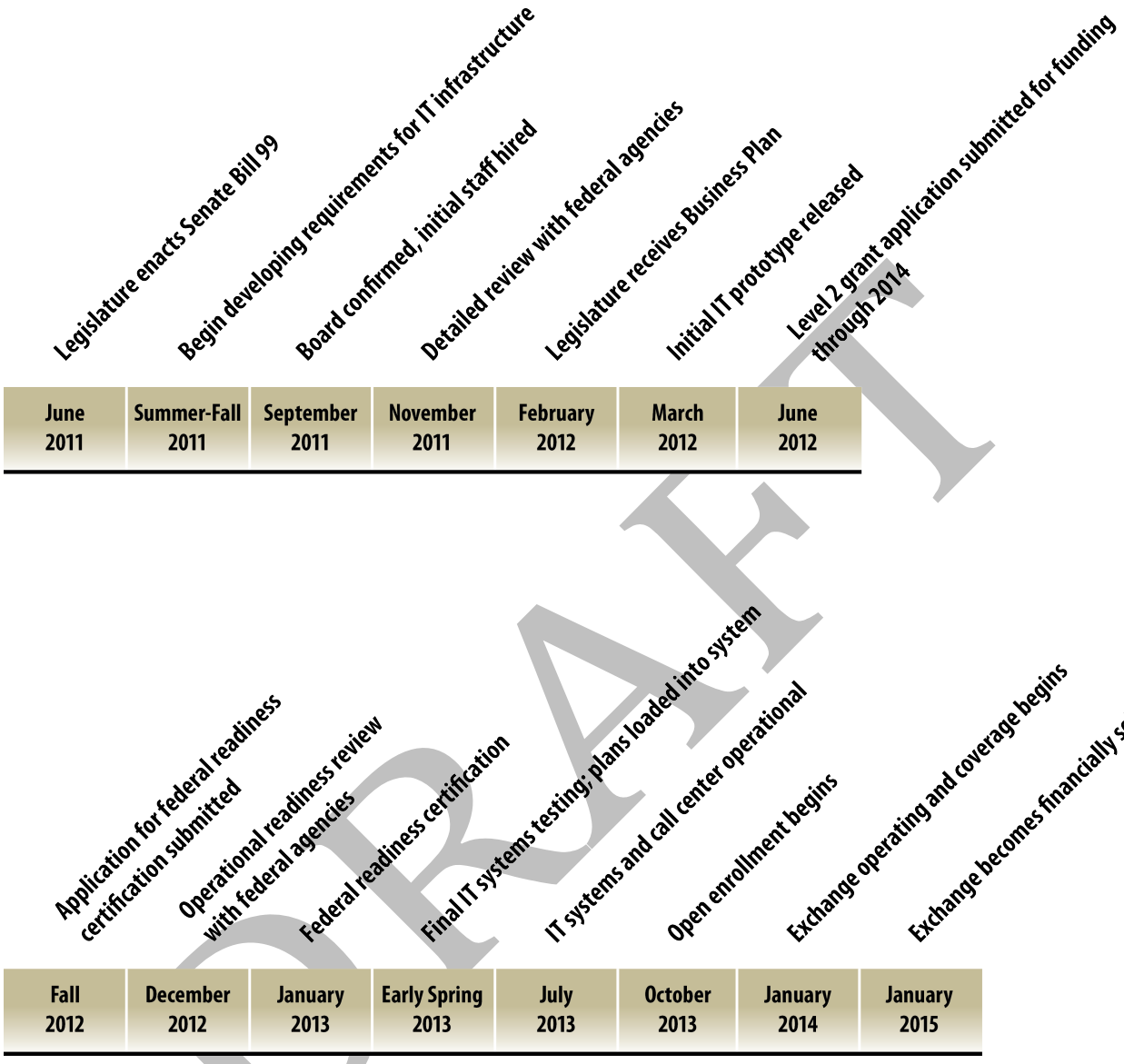
Senate Bill 99 established the Oregon Health Insurance Exchange as a public corporation, governed by a nine-member board of directors appointed by the Governor and confirmed by the Senate. The bill also created a bipartisan Legislative Oversight and Advisory Committee, composed of two representatives and two senators, to advise the corporation on matters concerning the implementation of the Health Insurance Exchange.

By developing its own exchange, Oregon can ensure it meets the unique needs of the state's consumers, businesses, and health insurance market.

Exchange board meetings are open to the public and allow for public participation through a public comment period. The legislation also established an Individual and Small Employer Consumer Advisory Committee to provide additional perspectives and input to the board.

The Exchange is funded by federal grants through 2014. To pay for operations beyond 2014, Senate Bill 99 establishes an administrative fee, which is a percentage of premiums for lives enrolled in the Exchange, charged to insurance companies. There is no state funding for start-up or ongoing operations of the Exchange.

*Timeline of Exchange Activities**



**Please see Appendix for more detailed operations timeline.*

What is the Exchange?

The Oregon Health Insurance Exchange is a central marketplace where consumers and small businesses can shop for health insurance plans and access federal tax credits to help them pay for coverage. Oregonians will be able to easily compare plans, find out if they are eligible for tax credits and other financial assistance, and enroll for health coverage through the Exchange's website. They also will be able to shop and enroll by calling a toll-free number and working with community-based navigators and agents.

The Exchange will serve two major customer groups: individual consumers and small businesses. While there will be similarities between the individual and small business products and services available in the Exchange, each portion of the Exchange will have unique characteristics and functions.

Individual Market Exchange

Plan comparison and selection

The Exchange's interactive web portal will allow consumers to make "apples-to-apples" comparisons of health insurance plans and costs. For example, a person could search for plans that include their doctor or hospital system, plans that have wellness programs or chronic disease management programs, plans that score highest on quality measures, or plans with the lowest costs.

Plans offered through the Exchange offer two distinct advantages to consumers. One, each plan will meet specific requirements set by the Exchange. The Exchange will use the federal minimum standard requirements as a baseline, potentially adding other requirements that ensure quality health plans are available across the state and that the types of plans available support other health system reforms in Oregon.

Second, the Exchange will grade each plan in areas like quality, care coordination, and network adequacy. Consumers will know that plans in the Exchange have been independently and objectively judged based on quality and value.

Eligibility and enrollment

The Exchange will be a central place Oregonians can go when looking for health coverage. Oregon's seamless, integrated systems will mean consumers can fill out one application through the Exchange to apply for and enroll in any type of health coverage.

By going online to the Exchange (or by filling out a paper application), Oregonians will be able to quickly find out if they are eligible to get help paying premiums for commercial health plans or if they are eligible for the Oregon Health Plan (Medicaid) or Healthy Kids (CHIP) program. The Exchange web portal will be able to pull from other state and federal data sources, cutting down the amount of paperwork that

Oregon's seamless, integrated systems will mean consumers can fill out one application through the Exchange to apply for and enroll in any type of health coverage.

has to be sent in and processed. Oregonians who do not qualify for federal or state assistance still can visit the Exchange to shop for and purchase health insurance plans.

Once the consumer has determined eligibility and chosen a health insurance plan, they can use the Exchange's web portal to enroll in the plan. Behind the scenes, the Exchange will forward information and the first month's premium payment (if applicable) securely to the insurance company or the Oregon Health Plan or Healthy Kids program. At that point, the insurance company will issue insurance cards and begin billing the consumer directly and coverage will begin. For consumers eligible for the Oregon Health Plan or the Healthy Kids program, the Exchange will transfer the enrollment choices to the Oregon Health Authority, who will complete the enrollment process. This process will be invisible to the consumer.

The Exchange will seamlessly determine eligibility for tax credits and state programs such as Healthy Kids and the Oregon Health Plan. Eligibility requirements are below:

- *Individual commercial plans* – Children and adults who do not have access to affordable coverage through an employer
- *Federal tax credits* – Children and adults up to 400 percent of federal poverty level ($89,000 for a family of four in 2011)
- *Oregon Health Plan or Healthy Kids* – Children up to 300 percent of federal poverty level
- *Oregon Health Plan* – Adults up to 138 percent of federal poverty level

Tax credits

Starting in 2014, many Oregonians will receive assistance paying their monthly premium using a federal tax credit for health plans offered through the Exchange. Based on income, some will also get additional help with cost-sharing expenses, such as co-pays and deductibles. To be eligible for the tax credits, Oregonians must be U.S. citizens or legal immigrants and not be eligible for other affordable insurance coverage, such as through an employer.

The tax credit is determined during the application process and is on a sliding scale based on income and the insurance plan chosen. Once a person is determined eligible for the tax credit, they can choose to have it as an advance payment or receive the credit when they file their taxes. The advance payment lowers the premium a person pays each month and is paid by the federal Department of the Treasury directly to the insurance company.

The Exchange will have a simple-to-use premium calculator to help Oregonians estimate their monthly premium bill.

Individual tax credit scenarios:

EXAMPLE #1: Family of four with income of $50,000
Income as a percentage of federal poverty level: 224 percent
Premium for plan: $750 per month
Premium tax credit: $452.50 per month
Actual family contribution: $297.50 per month

EXAMPLE #2: 40-year-old individual with income of $30,000
Income as a percentage of federal poverty level: 261 percent
Premium for plan: $375 per month
Premium tax credit: $166 per month
Actual contribution $209 per month

Sources: U.S. Treasury, Kaiser Family Foundation.

Note: The premiums for plans in the examples are hypothetical; premiums have not yet been set for Exchange plans.

Small Business Health Options Program (SHOP)

Providing health insurance to their employees is becoming increasingly challenging for Oregon's small businesses, which account for more than 50 percent of the private sector jobs in the state, according to the Small Business Administration (SBA). Only about 35 percent of businesses with fewer than 10 employees offer health insurance to workers, according to the Medical Expenditure Panel Survey (MEPS). The Oregon Health Insurance Exchange will make it easier for small businesses to offer insurance to their employees by providing expanded options for employers and their employees under a defined contribution model that reduces the administrative burden.

More options for employers and employees: defined contribution model

Although still awaiting federal requirements for SHOP, the Exchange has explored four major directions for plans offered in SHOP, including:

1. *Traditional.* The employer chooses one insurance company and plan that their employees must enroll in.
2. *Plan bundling.* The employer chooses one insurance company, but lets their employees select from all plans offered by that company.
3. *Multiple companies/one plan.* The employer selects a benefit plan level – such as bronze, silver, gold, and platinum, explained on page 13 – and the employees can select a plan from all companies.
4. *Full choice.* Employees can select from all companies and all plans.

The Oregon Health Insurance Exchange will make it easier for small businesses to offer insurance to their employees by providing expanded options for employers and their employees under a defined contribution model that reduces the administrative burden.

The fourth option, full choice, has resonated with the small business community and meets the Exchange's goal of providing innovative health insurance options to Oregonians. Known as a defined contribution model, option No. 4 would allow employers to pay a certain percentage of premiums or a set dollar amount and give their employees as much choice as they want. The Exchange will continue to work with the insurance community and small businesses on designing the defined contribution model.

Reduced administrative burden

Instead of having to research multiple insurance companies, small employers with 50 or fewer employees will be able to visit the Exchange website to choose insurance options for their employees. Once the employer makes its selections, employees can go to the Exchange to enroll. Although employees may select a range of plans from a range of carriers, the employers will only have to pay one bill to the Exchange, and the Exchange will remit the premiums to the participating insurance companies.

Tax credits

The Exchange also will help small businesses determine whether they are eligible for a federal tax credit to help cover the cost of coverage. The credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. While the Exchange will perform a preliminary calculation to determine whether employers may be eligible for the tax credit, the credit will be administered by the IRS. The Exchange will encourage employers to contact their tax adviser to take advantage of the credit.

To qualify for the tax credit, small businesses must:

- Provide health insurance to employees and cover at least 50 percent of the cost of coverage
- Employ less than the equivalent of 25 full-time workers (for example, an employer with fewer than 50 half-time workers may be eligible.)
- Pay average annual wages below $50,000.

Employers can be for-profit or tax-exempt. In 2014, the tax credit is worth up to 50 percent of a small business' premium costs (35 percent for tax-exempt employers). The tax credit phases out gradually for firms with average wages between $25,000 and $50,000 and for firms with the equivalent of between 10 and 25 full-time workers.

Small business tax credit scenarios:

EXAMPLE #1: Auto repair shop with 10 full-time employees
Wages: $250,000 total, or $25,000 per worker
Employee health care costs: $70,000
2014 tax credit: $35,000 (50 percent credit)

EXAMPLE #2: Restaurant with 40 part-time employees
Wages: $500,000 total, or $25,000 per full-time equivalent worker
Employee health care costs: $240,000
2014 tax credit: $40,000 (50 percent credit with phase-out)

EXAMPLE #3: Foster care nonprofit with 9 full-time employees
Wages: $198,000, or $22,000 per worker
Employee health care costs: $72,000
2014 tax credit: $25,200 (35 percent credit)

Source: IRS

Information for Better Health

Having insurance is a first step toward better health, but it is important to use health care services wisely – both to improve health and to keep unnecessary costs down. The Exchange will provide consumers with information and tools they need to best use their insurance benefits to improve health.

With so much information available to consumers, it can be difficult to judge which sources are reliable and trustworthy and which ones are less helpful. The Exchange will link people with the best resources available for all things health, such as exercise and nutrition, managing chronic health conditions, immunizations, and talking to your doctor. The Exchange also will connect consumers with helpful services offered by their health plans, such as nurse advice lines and preventive wellness programs.

For many Oregonians, the Exchange will be their first experience using health insurance and many of the terms will be unfamiliar or intimidating. The Exchange will help consumers learn the difference between co-pays and co-insurance, know what a deductible is, and understand what their benefits actually cover in ways that are easy to understand and use.

The Exchange will provide consumers with information and tools they need to best use their insurance benefits to improve health.

As part of its outreach and educational efforts, the Exchange Corporation will develop culturally appropriate materials in multiple languages using a variety of mediums, such as brochures, web pages, short informational videos, and social media (like Facebook or Twitter).

The Exchange will also provide referrals for all Oregonians to health care and health insurance resources within their local communities through the web portal and the customer call center.

Exchange Plan Requirements and Grading

The Oregon Health Insurance Exchange Corporation will establish quality standards for plans sold in the Exchange. In addition to certifying plans, the corporation will grade plans on a variety of criteria and publish those grades so that consumers can make meaningful comparisons.

In addition to certifying plans, the Exchange will grade plans on a variety of criteria and publish those grades so that consumers can make meaningful comparisons.

Certification of plans

The *Affordable Care Act* lays out general standards for "Qualified Health Plans (QHPs)" that will be certified by the state Exchanges. To be certified as a QHP, plans will have to provide essential health benefits, follow established limits on cost-sharing (like deductibles, co-payments, and out-of-pocket maximum amounts), and meet other requirements.

The federal government is developing specific requirements for essential benefits and for QHPs sold in the Exchanges, but states have the ability to have additional requirements. In Oregon, the Exchange Corporation is working with its Individual and Small Employer Consumer Advisory Committee and technical workgroups to determine how to measure quality in health plans.

Qualified health plans on the Exchange will be categorized into the following levels of coverage. The levels are based on how much of total benefit costs the plans pay.

- *Bronze plan* – represents minimum creditable coverage. Bronze plans cover 60 percent of the benefit costs of the plan.
- *Silver plan* – covers 70 percent of the benefit costs of the plan.
- *Gold plan* – covers 80 percent of the benefit costs of the plan.
- *Platinum plan* – covers 90 percent of the benefit costs of the plan.

In the individual market, consumers under the age of 30 can buy a "catastrophic" plan. These plans will only be available in the Exchange and will provide a minimum level of coverage though they will provide some upfront preventive care.

To be certified to sell in the Exchange, insurance companies must agree to offer at least one silver plan and one gold plan. Additionally, all insurance companies in the individual and small group markets in Oregon must provide a bronze plan. Insurers also must be licensed and in good standing with the state, agree to charge the same premium for the same plan inside and outside of the Exchange, and meet other requirements to participate in the Exchange.

Grading of plans

The Exchange will publish grades for qualified health plans, to help consumers choose the plan that best meets their needs. The Exchange will grade plans on a variety of measures, including quality, care coordination, provider network adequacy, customer service, and price. The Exchange Corporation is working with Quality Corporation, the Oregon Health Authority, the Insurance Division, and stakeholder groups to establish consistent quality indicators while awaiting federal government regulations regarding grading.

The Corporation will work with the Insurance Division and the Oregon Health Authority to collect necessary information from insurance companies for certification and grading, so that companies submit information only once.

Customer Service and Outreach

In developing the Oregon Health Insurance Exchange, the corporation is centering its efforts around its two major customer groups: individual consumers and small businesses. To ensure it can best serve those groups, the corporation is developing a robust customer service program as well as a broad communications and outreach plan to reach all Oregonians.

The corporation is developing an extensive customer service program, including a call center with highly trained customer service staff, community-based "navigators," and insurance agents.

Customer Service

The Exchange will be a central place where Oregonians can turn for health coverage information and assistance. The corporation is developing an extensive customer service program, including a call center with highly trained customer service staff, community-based "navigators," and insurance agents.

Customers will be able to turn to the Exchange not only for help enrolling, but for referrals to other entities if necessary. Through its customer service program, the Exchange will provide the following:

- Expertise in eligibility, enrollment, and program specifications.
- Public education activities to raise awareness about the Exchange.
- Fair, accurate, and impartial information.
- Help enrolling in Exchange plans.
- Help for consumers with complaints about their plans.
- Information in appropriate languages for those with limited English proficiency.
- Accessible information for those with disabilities.

The Exchange will develop its customer service plan in spring 2012. An important part of that plan will be Oregon's "navigator" program, which will use community-based organizations to assist Oregonians throughout the state. In creating its navigator program, Oregon is looking to build off the success of similar local, grassroots assistance programs, such as the Senior Health Insurance Benefits Assistance (SHIBA) program and the Healthy Kids program. The SHIBA program uses community-based organizations and a network of volunteers throughout the state to assist Medicare beneficiaries and their families. The Healthy Kids program partnered with community organizations to help enroll more than 100,000 children.

The corporation also views insurance agents as key to the Exchange's success. The corporation will develop a certification program for agents who sell plans in the Exchange and a referral service for consumers who request to work with an agent. In addition, the corporation is exploring ways to give agents the ability to sell all plans in

the Exchange – from a variety of insurance companies – and work on behalf of consumers.

Some consumers in particularly challenging or unique situations may need a higher level of assistance. The Exchange will have specially trained staff and partners throughout the state to help those Oregonians.

Communications and Outreach Plan

The Exchange is approaching communications and outreach in five phases, beginning with engaging stakeholders and developing partnerships, leading to a broader effort to educate Oregonians and small businesses about the Exchange so they are prepared to begin enrolling by 2014.

Technology Solution

Oregon is one of five states to receive a federal Early Innovator Grant to develop an IT solution to support its health insurance exchange. At the time Oregon received the Early Innovator Grant, the Department of Human Services (DHS) and the Oregon Health Authority (OHA) were modernizing and automating their aging eligibility systems and processes. Oregon chose to pursue a joint solution for determining eligibility for the Exchange and federal assistance programs such as Medicaid using an enterprise software platform of integrated commercial, off-the-shelf (or COTS) products.

An off-the-shelf technology solution allows Oregon to configure existing proven products to meet its needs, rather than use the time-consuming and expensive process of building new systems from scratch.

This solution allows Oregon to configure existing proven products to meet its needs, rather than use the time-consuming and expensive process of building new systems from scratch. It also gives the state the flexibility to integrate other systems into the enterprise platform over time.

As an Early Innovator state, Oregon is sharing its work products and solutions with other states and its federal funding partner.

Product selection

Oracle was chosen to provide the enterprise software platform after an extensive vendor selection process. One of the key elements of this platform is the "rules engine" that is the heart of the system's configurability. Using special word processing templates, business and policy analysts are able to convert program rules into Oracle formats to implement functions such as eligibility determination and financial management (billing and payments) into the web portal.

Development process

The team designing and developing the Exchange is using an "iterative process," which entails making incremental and evolutionary changes to the system every three weeks. This approach provides greater flexibility to adapt to changing requirements while moving the project forward.

Governance structure

The two-year project is managed by OHA. An Executive Steering Committee consisting of the directors of the Exchange, OHA, DHS, and the administrator of the Insurance Division provides governance for the project. There is also a Tactical Steering Committee, made up of staff from all the impacted agencies above, including Early Innovator project management staff, which is responsible for operational decisions. Oregon consults frequently with the federal Center for Consumer Information and Insurance Oversight (CCIIO), and undergoes rigorous, periodic "gate reviews" with the center to affirm the project is on target. OHA is also required to provide regular updates to the Oregon Legislature.

Enrollment and Financial Projections

PLACEHOLDER

Appendix

PLACEHOLDER

Information Technology Report

December 16, 2011

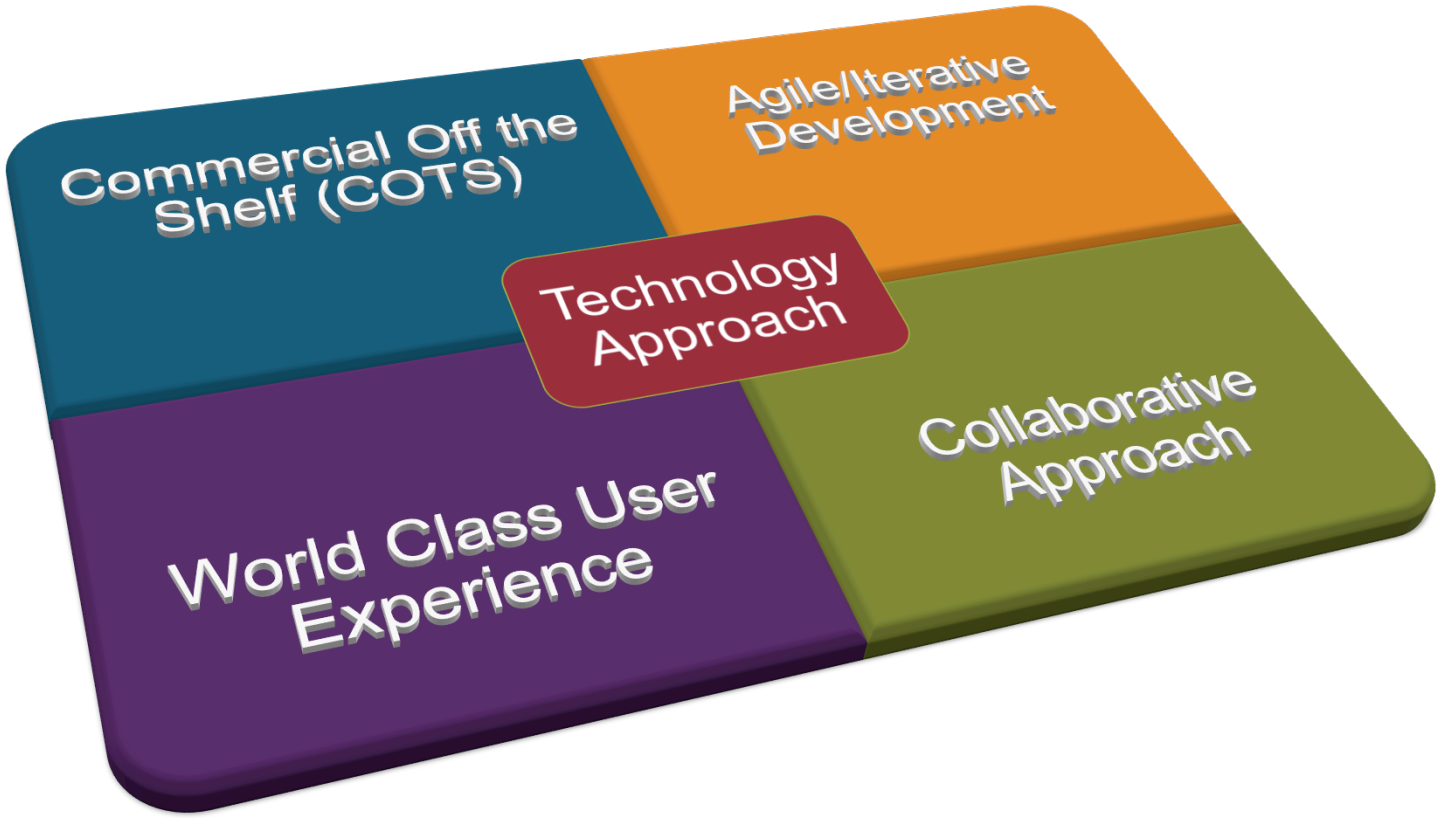
Aaron Karjala

Oregon Health Insurance Exchange Corporation

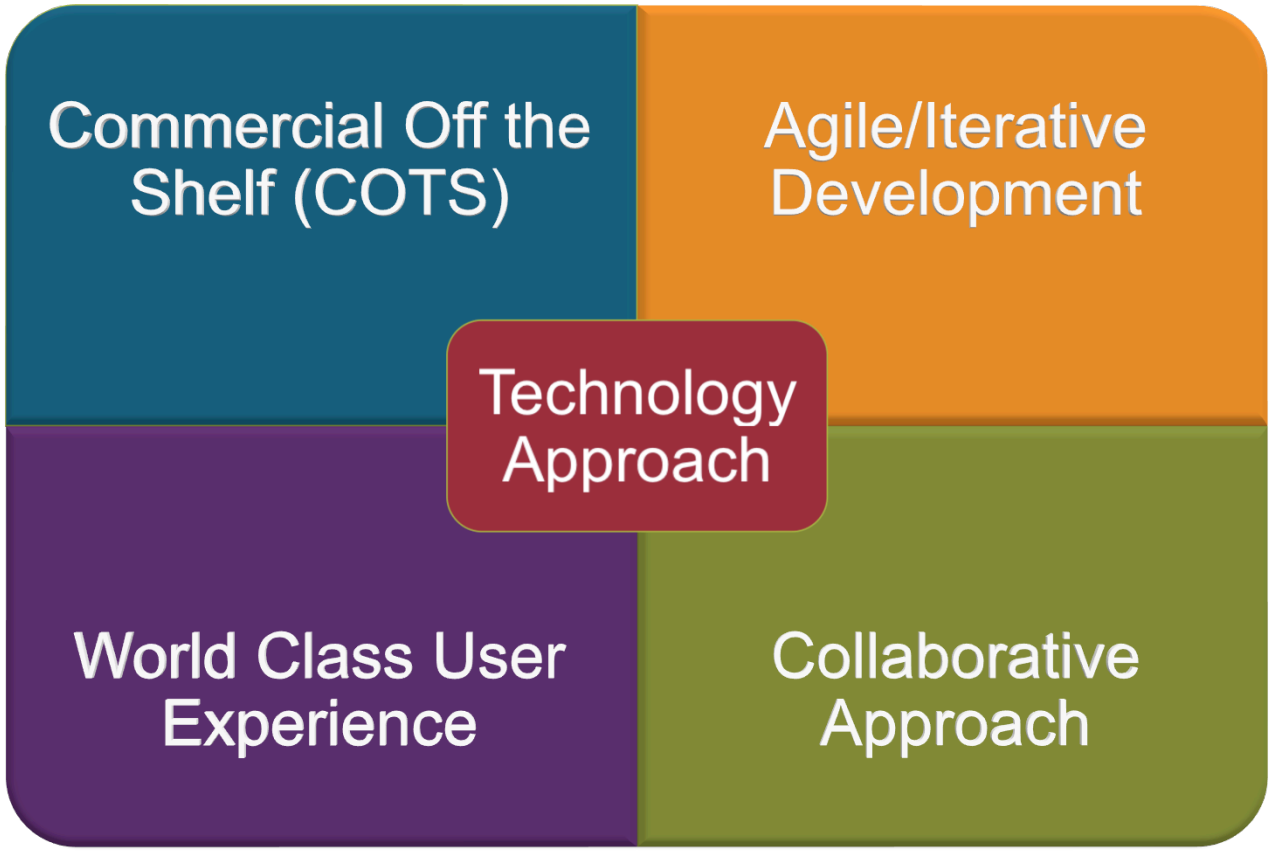
BACKGROUND

Date	Description
Fall 2009	DHS conducted a vendor fair to explore how to best automate their aging eligibility systems. Found a Commercial Off the Shelf (COTS) strategy to be most effective.
Dec 2010	Oregon Health Authority (OHA) applied for Early Innovator grant, leveraging 2009 COTS strategy.
Feb 2011	OHA received $48M from the Center for Consumer Information and Insurance Oversight (CCIIO) and $7M from the Center for Medicare and Medicaid Services (CMS).
June 2011	Legislature enacted Senate Bill 99 establishing the Exchange Corporation.
July 2011	OHA chose Oracle Health and Human Services COTS solution. Exchange Corporation partnered with OHA for exchange information technology development.

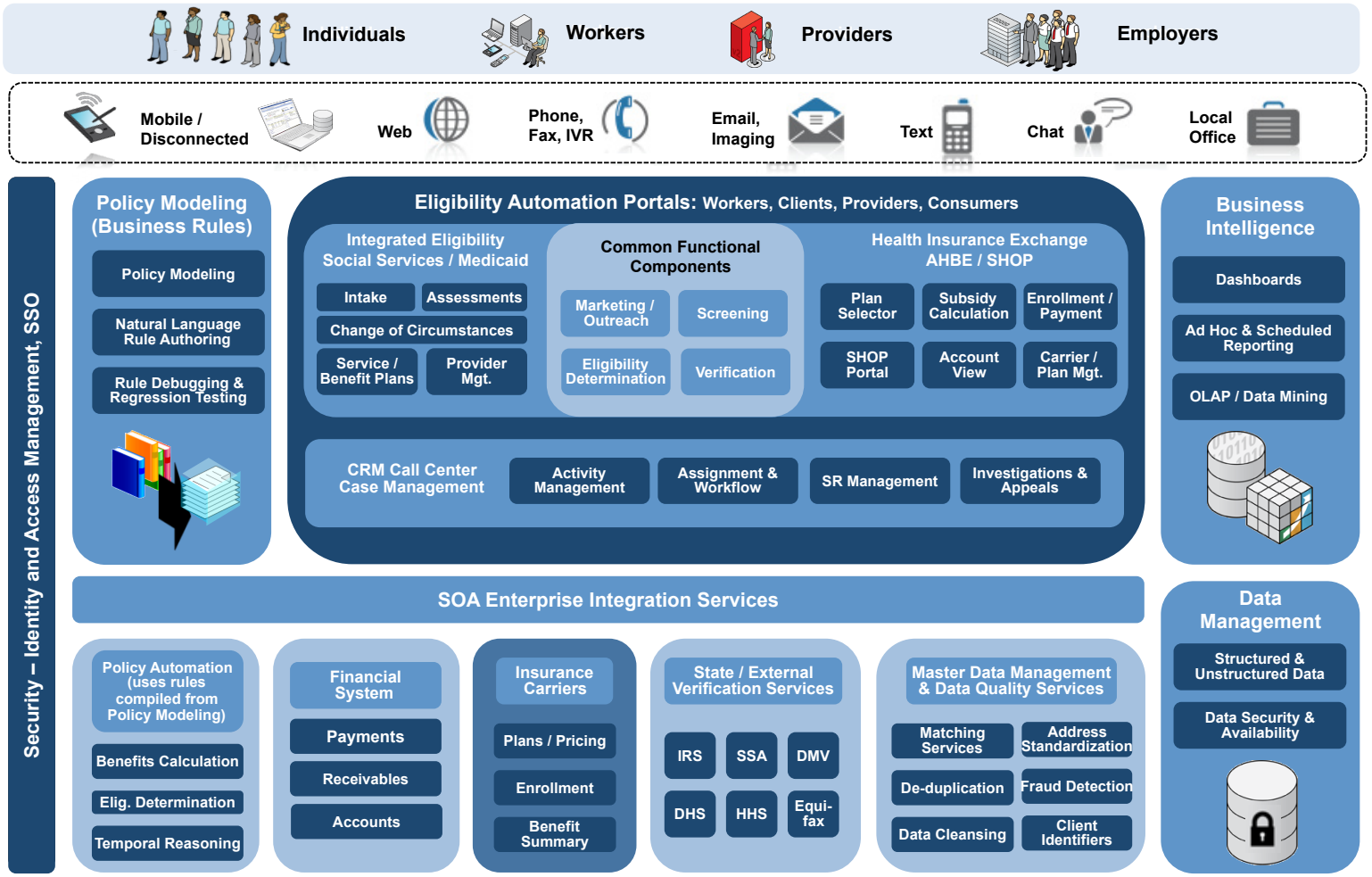
TECHNOLOGY APPROACH



TECHNOLOGY APPROACH



TECHNOLOGY – ONE VIEW



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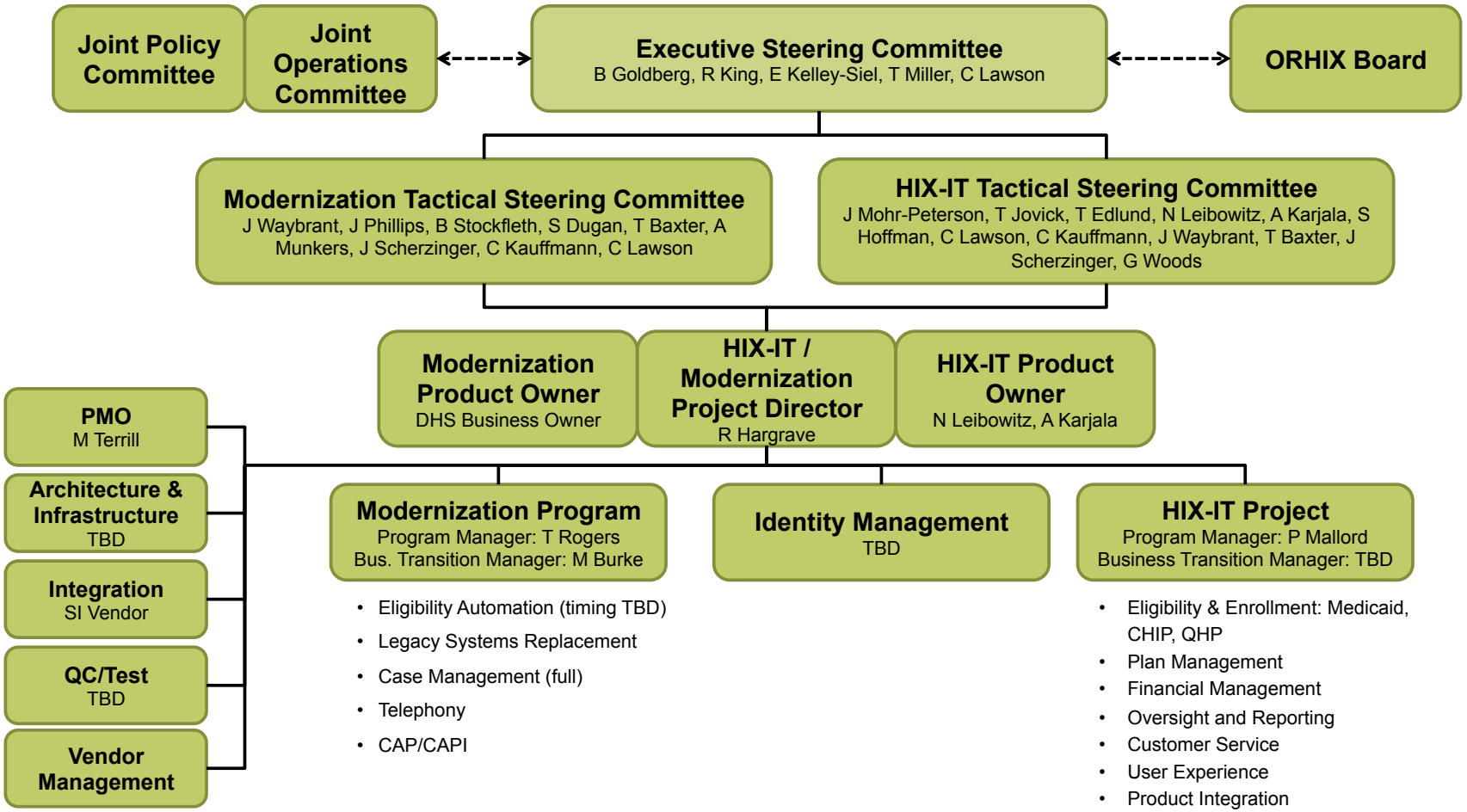

BACKGROUND

Risk	Mitigations
Aggressive Timeline	• Focused Project Management • Close Partnership with OHA and Feds • Prioritize Effort in Critical Exchange Areas
Requirements • Continuously Emerging • Sheer Number – 2,000 to 3,000 • Complexity	• Iterative Project Approach • Prioritization of Work • Scope Management
Complexity of Interfaces/Integration	• "Open" COTS Software – Built for Integration • Good Definition of Information (Data) and Where It Resides • Define and Adhere to Standards
Managing Multiple Organizations	• Active Governance Structure and Processes • Exchange Corporation Performance Management Process


Questions?
www.orhix.org

Coordinated Care Organization Implementation Proposal

House Bill 3650
Health Care Transformation

Oregon Health Policy Board

The nine-member Oregon Health Policy Board (OHPB) serves as the policy-making and oversight body for the Oregon Health Authority. The Board is committed to providing access to quality, affordable health care for all Oregonians and to improving population health. Board members are nominated by the Governor and must be confirmed by the Senate. Board members serve a four-year term of office.

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Chair, Portland

Lilian Shirley, BSN, MPH, MPA
Vice-Chair
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Michael Bonetto, PhD, MPH, MS
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Eileen Brady
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Chuck Hofmann, MD, MACP
Baker City

Joe Robertson, MD, MBA
Portland

Nita Werner, MBA
Beaverton

Table of Contents

CCO Implementation Proposal
House Bill 3650 Health Care Transformation

1. Executive Summary

(Forthcoming)

2. Existing Market Environment and Industry Analysis

Target Population

(Forthcoming)

Population Characteristics and Health Status

(Forthcoming)

Current Delivery System for Target Population

(Forthcoming)

3. Opportunities for Achieving the Triple Aim: Improving Health, Improving Health Care and Reducing Cost

Coordinated Care Organizations (CCOs) are primary agents of health system transformation. They will be responsible for integrated and coordinated health care for their community members' physical health, addictions and mental health services, and by 2014, oral health care—with a focus on prevention, improving quality, accountability, eliminating health disparities and lowering costs. HB 3650 directs CCOs' delivery system networks to emphasize patient-centered primary care homes, evidence-based practices, and health information technology to improve the coordination of care for individuals with chronic conditions and to increase preventive services that will improve health and health care for eligible members—all managed within a global budget. The CCO model of care will promote efficiency and quality improvements in an effort to reduce year-over-year cost increases while supporting the development of local accountability for the health of CCO members.

Description of Oregon's Integrated and Coordinated Health Care Model

The Oregon Health Plan (OHP) implemented a Medicaid managed care system in the mid-1980s and the prioritized list of health services in 1994. Despite the many successes of the Oregon Health Plan, growth in Medicaid expenditures have continued to outpace state general fund revenue and beneficiaries with the greatest need for coordinated care often see multiple providers across multiple sites of care while facing complex treatment and medication regimens. In particular, the OHP goal of integrating care across physical, mental, and dental health was never fully achieved, nor was the goal of seamless management of health care for individuals eligible for both Medicare and Medicaid. As the policy-making and oversight body for the Oregon Health Authority and its programs, the Oregon Health Policy Board ("OHPB" or "the Board") believes better integration and coordination of care can generate greater value for our health care dollar and slow the growth of medical inflation.

Oregon's existing Medicaid delivery system is made up of 16 fully or partially capitated managed physical health care plans (MCOs), 8 dental health organizations (DCOs), and 10 mental health organizations (MHOs) with care spanning a variety of settings including long term care. In addition, the fact that individuals dually eligible for Medicare and Medicaid face differing program regulations, benefit packages and provider networks can create a confusing, fragmented system for beneficiaries. Benefits are administered and paid for by different systems, leading to an inefficient duplication of services and infrastructure, unintended cost shifts and less than optimal outcomes. These silos lead to care that is uncoordinated if not unnecessary, and, as a result, is fragmented and more expensive than it needs to be, especially for the most medically vulnerable individuals—those with multiple chronic conditions.

Oregon's health system transformation represents an evolution of the Oregon Health Plan. Coordinated Care Organizations (CCOs) will provide a stronger focus on primary and preventive care, evidence-based services, and more effective management of care with the end goal of moving from fragmentation to organization and delivering the right care in the right place at the right time to patients who are fully engaged.

The key elements of the coordinated and integrated health care delivery system envisioned by HB 3650 are patient-centered primary care homes, coordination of care across categories of care and funding streams, patient activation, and aligning incentives that reward providers and beneficiaries for achieving good outcomes. In order to incent integration and efficiency, CCOs will receive all eligible Medicaid and—in the case of individuals who are dually eligible—Medicare funding through a single global budget designed to allow maximum flexibility to support both innovation and investment in evidenced-based care. Triple Aim-oriented measures of health outcomes, quality and efficiency will help ensure that CCOs improve upon the existing managed care system and will enable incentives for exceptional performance.

Approximately 200,000 additional Oregonians will become eligible for Medicaid in 2014 with the implementation of Patient Protection and Affordable Care Act. With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. Roughly 78% of eligible individuals are enrolled in a managed physical health care plan, 88% in a MHO, and 90% in a Dental Care Organization (DCO). HB 3650 directs that OHA enroll as many of the remaining eligibles currently in FFS into a CCO. By creating community-based CCOs that focus on prevention and primary care and the needs of their particular communities, we believe Oregon will be optimally positioned to provide for better health for the newly eligible members, many of whom will have been at best sporadically covered with no regular source of care.

By April 2012, Oregon will submit a demonstration proposal to the Centers for Medicare and Medicaid Services (CMS) that will align and integrate Medicare and Medicaid benefits and financing to the greatest extent possible for individuals who are eligible for both programs. A successful proposal will lead to a three-way contract between CMS, the state and CCOs in order to simplify and unify funding and rules that plans face when serving individuals who are dually eligible. The proposal will detail how the state will structure, implement, and evaluate an integrated delivery system and payment model aimed at improving the quality, coordination, and cost-effectiveness of care for individuals who are dually eligible. CMS will review and approve relevant elements of the overall health systems transformation plan as they pertain to dually eligible beneficiaries, including the model of care, performance metrics, financial solvency criteria, and other aspects of the plan.

Financial Projections for Greater System Efficiency and Value

(Forthcoming from HMA)

Potential opportunities for shared savings with Medicaid and Medicare

(Forthcoming from HMA)

4. Coordinated Care Organization Certification Process

The OHPB recommends that prospective CCOs submit applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650, including being prepared to enroll all eligible persons within the CCO's proposed service area.

Pending direction and approval by the Legislature during the February 2012 session, the Board recommends that OHA promulgate administrative rules describing the CCO application process and criteria. Once the criteria have been finalized, the Board recommends the following application process for prospective CCOs (see Section 9 of this document for a timeline):

- CCO criteria will be posted online by OHA
- OHA will release a "Request for CCO Application"
- CCOs applicants will submit letters of intent
- CCO applicants will submit applications to OHA
- OHA will evaluate CCO applications (CMS will collaborate on the approval of CCOs with respect to individuals who are dually eligible)
- OHA will certify CCOs (CMS will collaborate on the approval of CCOs with respect to individuals who are dually eligible)

The OHPB does not favor a competitive bidding or Request for Proposals process. Instead, it recommends that the Request for Applications identify the criteria organizations must meet to be certified as a CCO. In addition, the application will include the relevant Medicare plan requirements and will build on the existing CMS Medicare Advantage application process, to streamline the process for any plans that have previously submitted Medicare Advantage applications. The request for applications will be open to all communities in Oregon and will not be limited to certain geographic areas.

Evaluation of CCO applications will account for the developmental nature of the CCO system. CCOs, OHA and partner organizations will need time to develop capacity, relationships, systems and experience to fully realize the goals envisioned by HB 3650. In all cases, CCOs will be expected to have plans in place for meeting the criteria laid out in the application process and making sufficient progress in implementing plans and realizing the goals established by HB 3650.

5. Coordinated Care Organization (CCO) Criteria

In order to be certified as a CCO, organizations will be asked to address the criteria outlined in Sections 4 through 13 of HB 3650 and to illustrate how their organization and systems support the Triple Aim. The OHPB recommendations for CCO criteria, outlined below, were developed from a combination of stakeholder workgroup input, public comment, OHPB-sponsored community meetings held throughout the state, and public and invited testimony at Board meetings, as well as Board deliberations.

Governance and organizational relationships

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

<u>Governing Board</u>

CCO organizational structures will vary to meet the needs of the communities they will serve. There is no single governance solution, and there is risk in being too prescriptive beyond the statutory definition of a CCO governing board. Instead, the OHPB recommended governing board criteria support a sustainable, successful organization that can deliver the greatest possible health within available resources, where success is defined through the Triple Aim.

The OHPB recommends that, as part of the certification process, a CCO should articulate:

- How individuals bearing financial risk for the organization make up the governing board's majority interest,

- How the governing board includes members representing major components of the health care delivery system,
- How consumers will be represented in the portion of the Board that is not composed of those with financial risk in the organization; and
- How the Board makeup reflects the community needs and supports the goals of health care transformation.

Community Advisory Council (CAC)

The OHPB recommends that at least one member from the Community Advisory Council (chair or co-chairs) also serve on the Board to ensure accountability for the governing board's consideration of Council policy recommendations. There should be transparency and accountability for the governing board's consideration and decision making regarding recommendations from the CAC.

Clinical Advisory Panel

The OHPB encourages but would not require potential CCOs to establish a Clinical Advisory Panel (CAP) as a means of assuring best clinical practices. If a Clinical Advisory Panel is established, representation on the Board could be required, as with the Community Advisory Council.

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

- What are the criteria and process for selecting members on the Board, Community Advisory Council and any other councils or committees of the Board?
- How will the Community Advisory Council and any other councils or committees of the Board support and augment the effectiveness of Board decision-making?
- What are the structures initially and over time that will support meaningful engagement and participation of CAC members, and how will they address barriers to participation?

Partnerships

HB 3650 encourages partnerships between CCOs and local mental health authorities and county governments in order to take advantage of and support the critical safety net services available through county health departments and other publicly supported programs. Unless it can be shown why such arrangements would not be feasible, HB 3650 requires CCOs to have agreements with the local mental health authority regarding maintenance of the mental health safety net and community mental health needs of CCOs members, and with publicly funded providers for payment for certain point-of-contact services. The Board directs OHA to review CCO applications to ensure that statutory requirements regarding county agreements are met.

Community Needs Assessment

The Oregon Health Policy Board recommends that CCOs partner with their local public health authority and hospital system to develop a shared community needs assessment that includes a focus on health equity issues and health disparities in the community. Although community needs assessments will evolve over time as relationships develop and CCOs learn what information is most useful, the Board recommends that OHA work with communities to create as much standardization as possible in the

components of the assessment and data collection so that CCO service areas can be meaningfully compared, recognizing that there will be some differences due to unique geographic settings and community circumstances.

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

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

Patient Rights and Responsibilities, Engagement, and Choice

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

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

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

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

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

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

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

The OHPB recommends that members enrolled in CCOs should be actively engaged partners in the design and implementation of their treatment and care plans through ongoing consultation regarding preferences and goals for health maintenance and improvement. Member choices should be reflected in the development of treatment plans and member dignity will be respected. Under this definition, members will be better positioned to fulfill their responsibilities as partners in the primary care team at the same time that they are protected against underutilization of services and inappropriate denials of services. In addition to any other consumer rights and responsibilities established by law, the Board recommends that CCOs be asked to demonstrate how they will:

- Encourage members to be active partners in their health care, understanding to the greatest extent feasible how the approach to activation accounts for the social determinants of health.
- Engage members in culturally appropriate ways.
- Educate members on how to navigate the coordinated care approach.
- Encourage members to use wellness and prevention resources and to make healthy lifestyle choices.

Delivery System: Access, patient-centered primary care homes, care coordination and provider network requirements

- ***<u>Section 4(1)(b) Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and for comprehensive care management in all settings.</u>***
- ***Section 4(1)(c) Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible.***
- ***Section 4(1)(d) Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long-term care setting.***
- ***Section 4(1)(e) Members receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources, including through the use of certified health interpreters, community health workers, and personal health navigators who meet competency standards developed by the Authority.***

- ***Section 4(1)(f) Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations.***

- ***Section 4(1)(j) Each CCO prioritizes working with members who have high health care needs, multiple chronic conditions, mental illness or chemical dependency and involves those members in accessing and managing appropriate preventive, health, remedial and supportive care and services.***
- ***Section 4(1)(n) Each CCO participates in the learning collaborative described in ORS 442.210(3).***
- ***Section 6(2) Each CCO shall implement, to the maximum extent feasible, patient centered primary care homes, including developing capacity for services in settings that are accessible to families, diverse communities and underserved populations. The CCO shall require its other health and services providers to communicate and coordinate care with patient-centered primary care homes in a timely manner using health information technology***.
- ***Section 6(3) Standards established by the authority for the utilization of patient centered primary care homes by CCOs may require the use of federally qualified health centers, rural health clinics, school-based health clinics and other safety net providers that qualify as patient centered primary care homes to ensure the continued critical role of those providers in meeting the needs of underserved populations.***

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

<u>Patient-Centered Primary Care Homes</u>

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

Building on this work, the OHPB recommends that CCOs demonstrate how they will use PCPCH capacity to achieve the goals of health system transformation including:

- How the CCO will partner with and/or implement a network of patient-centered primary care homes as defined by Oregon's standards to the maximum extent feasible, as required by HB 3650.

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

Care Coordination

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

The OHPB recommends that CCOs demonstrate the following elements of care coordination in their applications for certification:

- How they will support the flow of information, identify a lead provider or care team to confer with all providers responsible for a member's care, and a standardized follow-up approach in the absence of full health information technology capabilities.
- How they will work with their providers to develop the partnerships necessary to allow for access to and coordination with social and support services, including crisis management services.
- How they will develop a tool for provider use to assist in the education of members about care coordination and the responsibilities of each in the process of communication.

The Board recommends that CCO be required to describe the evidence-based or innovative strategies they will use within their delivery system networks to ensure coordinated care, especially for members with intensive care coordination needs, as follows.

- *Assignment of responsibility and accountability:* CCOs must demonstrate that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions, as required by HB 3650.
- *Individual care plans:* As required by HB 3650, CCOs will use individualized care plans to the extent feasible to address the supportive and therapeutic needs of each member, particularly those with intensive care coordination needs. Plans will reflect member or family/caregiver preferences and goals to ensure engagement and satisfaction.

- *Communication*: CCOs will demonstrate that providers have the tools and skills necessary to communicate in a linguistically and culturally appropriate fashion with members and their families or caregivers and to facilitate information exchange between other providers and facilities (e.g., addressing issues of health literacy, language interpretation, having EHR capabilities, etc.).

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

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

<u>Care Integration</u>

- *Mental Health and Chemical Dependency Treatment:* HB 3650 requires the OHA to continue to renew contracts or ensure that counties renew contracts with providers of residential chemical dependency treatment until the provider enters into a contract with a CCO but no later than July 1, 2013.
- *Oral Health:* By July 1, 2014, HB 3650 requires each CCO to have a formal contractual relationship with any dental care organization that serves members of the CCO in the area where they reside. OHPB recommends shared accountability to align financial incentives for cost-effectiveness and to discourage cost shifting.
- *Hospital and Specialty Services:* Adequate, timely and appropriate access to hospital and specialty services will be required. Hospital and specialty service agreements should be established that include the role of patient-centered primary care homes and that specify: processes for requesting hospital admission or specialty services; performance expectations for communication and medical records sharing for specialty treatments, at the time of hospital admission or discharge, for after-hospital follow up appointments. The OHPB recommends the CCO demonstrate how hospitals and specialty services will be accountable to achieve successful transitions of care.

<u>Alternative Dispute Resolution</u>

(Forthcoming)

Health Equity and Eliminating Health Disparities

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

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

Payment Methodologies that Support the Triple Aim

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

To encourage improved quality and efficiency in the delivery of services, it will be necessary for CCOs to move from a predominantly fee-for-service system to alternative payment methods that base reimbursement on the quality rather than quantity of services provided. The Board recommends that CCOs demonstrate how their payment methodologies promote the following principles:

- Reimburse providers on the basis of health outcomes and quality measures instead of the volume of care;
- Hold organizations and providers accountable for the efficient delivery of quality care;
- Limit increases in medical costs;
- Promote prevention, early identification and intervention of conditions that lead to chronic illnesses;
- Provide comprehensive coordination or create shared responsibility across provider types and levels of care, using such delivery systems such as patient-centered primary care homes; and
- Utilize evidence-based practices and health information technology to improve health and health care.

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

Health Information Technology

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

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

<u>Electronic Health Records Systems (EHRs)</u>

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

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

<u>Health Information Exchange (HIE)</u>

HITOC recommends that CCOs facilitate electronic health information exchange in a way that allows all providers to exchange a patient's health information with any other provider in that CCO. HIE is a foundational component of care coordination because it enables providers to access pertinent health

information when and where it is needed to provide the best care possible and to avoid performing duplicative services. HITOC recommends that CCOs be required to ensure that every provider is:

- **Either** registered with a statewide or local Direct-enabled Health Information Service Provider (HISP) (Direct secure messaging will be available to all providers as a statewide service, and while EHR vendors will continue to develop products with increasingly advanced Direct functionality, using Direct secure messaging does not require an EHR system. Registration will ensure the proper identification of participants and secure routing of health care messages, and the e-mail address provided with Direct secure messaging registration will be accessible from a computer, smart phone or tablet, and through EHR modules over time,
- **Or** is a member of an existing Health Information Organization (HIO) with the ability for providers on any EHR system (or with no EHR system) to be able to share electronic information with any other provider within the CCO network.

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

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

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

6. Global Budget Methodology

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

Populations Included in Global Budget Calculations

With very few exceptions, all Medicaid populations in Oregon are to be enrolled in CCOs and paid under the global budget methodology. An overview of the eligible CCO populations and their current managed care enrollment can be found in Appendix B. Approximately, 78% of people who are eligible for Medicaid are enrolled in a managed health care organization, 88% in a MHO, and 90% in a Dental Care Organization (DCO).[1] HB 3650 directs OHA to enroll as many of the remaining eligible individuals (who are currently in fee-for-service) into a CCO as possible.

Service/Program Inclusion and Alignment

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

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

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

On the remaining 13 percent of non-long term care Medicaid expenditures, the OHPB believes exceptions to service or program inclusion should be minimal. However, consideration could be given to

[1] Citizen Alien Waived Emergent Medical (CAWEM) beneficiaries and individuals who are partially dual eligible for Medicaid and Medicare—including Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiaries (SLMB)—are not included in this calculation.

CCO requests to postpone inclusion of one or more services or programs on the grounds that their inclusion would negatively impact health outcomes by reducing available funding, access or quality. CCOs are strongly encouraged to develop strategic partnerships within their community in order to successfully manage comprehensive global budgets.

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

Global Budget Rate Development

OHPB recommends an overall global budget strategy that holds CCOs accountable for care costs but not enrollment growth. This strategy suggests an overall budgeting process that builds off of the current capitation rate methodology, but also includes a broader array of Medicaid services and/or programs. CCOs' initial global budgets will include:

- A combined capitated portion that includes the physical health plan, mental health organization and, if included, dental care organization capitation payments.
- Clearly defined Medicaid services or programs not currently included in capitation payments as add-on payments to the capitated portion.

At least initially, CCO capitation rate setting would combine the information provided by organizations seeking CCO certification with a method similar to the lowest cost estimate approach OHA took in setting rates for the first year of the 2011-13 biennium. This approach provides a key role for plans in determining appropriate rates and potential efficiencies that could be realized under a transformed delivery system tailored to meet the needs of the community it serves. As CCO transformation evolves over subsequent years, the OHPB believes the approach to global budget calculation will evolve as well.

Modified Lowest Cost Estimate Approach

Under this approach, potential CCOs would submit a completed Base Cost Template using internal cost data that is representative of a minimum base population and the benefit package in effect as of January 1, 2012. As previously mentioned, the OHPB does not favor a competitive bidding but OHA actuaries would review the submission for completeness and soundness and establish a base rate. Once a base rate is established, the state actuaries would use a risk adjustment methodology to arrive at rates for previously uncovered populations and areas.

More specifically, in order to establish rates, OHA would gather estimated costs that utilize the most reliable cost data from potential CCOs in order to produce a base cost while addressing actuarial soundness, CCO viability, and access to appropriate care. This cost data would indicate the lowest rate a CCO can accept in their "base region," based on current population, geographic coverage and benefit

package (the "CCO Base Cost Template" referenced above). OHA will use the CCO Base Cost Template as the foundation for the CCO capitation rates.

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

The OHPB recommends that initial CCO global budget amounts be established for one year. Meanwhile, the Board recommends that stakeholders and OHA explore the possibility of establishing global budgets that could be enacted on a biennial or multiyear basis.

For subsequent years, stakeholders have indicated support for continuing to adjust payments to CCOs based on member risk profiles under the current CDPS process. Stakeholders have encouraged OHA to investigate the possibility of including pharmacy data and expanded demographic data into CDPS.

Pending direction and approval by the Legislature during the February 2012 session, the Board recommends that OHA carry out the following process for prospective CCOs (see Section 9 of this document for a timeline):

- Finalize CCO definition/scope and process
- Release CCO estimated cost submission process document
- Collect comments on estimated cost submission process document
- Make final changes to estimated cost submission process
- Release of CCO case cost template
- Release Notice of Intent to contract as CCO
- Collect base cost template
- Review and certification of CCO rates
- Conduct final review of CCO capitation rates
- Submit CCO capitation rates to CMS
- Submit contracts to CCOs

Process for Review of Estimated Costs Submission

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

<u>Review of Estimated Costs and Capitation Rates</u>

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

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

The OHA Actuary will assess actuarial soundness at the CCO and region level, and will confer with the CCO regarding any questions or issues that need to be resolved. Additional calculations may be required to ensure that CCO rates in aggregate meet the 2011-13 legislatively approved budget.

Blended Funding for Individuals who are Dually Eligible for Medicare and Medicaid

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

CMS has offered states the previously unavailable opportunity to coordinate Medicare and Medicaid funding through three-way contracts between CCOs, the state, and CMS. The Medicare portion of these rates will be developed in partnership with CMS. OHPB recommends that three-way contracts with CMS maintain current Medicare Advantage rates at the outset and then gradually incorporate savings to be shared among all parties as a result of CCO efficiencies.

Quality Incentive Payments

The OHPB strongly supports linking CCO global budget payments to quality reporting metrics on both clinical processes and health outcomes. However, the Board recognizes such an incentive structure will be difficult to initiate in the first year of CCO operation. So initially, metrics will be utilized to ensure adequate CCO performance and create a data baseline. After the initial period, metrics should be used to determine exceptional performers who would qualify for incentive rewards. The Board supports Oregon's discussions with CMS on developing an incentive program as early as possible and is following the progress of the Massachusetts Blue Cross/Blue Shield Alternative Quality Contract and other new incentive models such as the Five-Star Quality Rating for Medicare Advantage plans to garner lessons that may be applied to CCO global budget development.

7. Accountability

OHA's Accountability in Supporting the Success of CCOs

The OHPB recommends that OHA be an active partner in health care transformation and support CCOs by:

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

CCO Accountability

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

Accountability for each aspect of the Triple Aim—better health, better care and lower costs—is a central tenet of health system transformation. As required by HB 3650, CCOs will be held accountable for their performance on for outcomes, quality, and efficiency measures identified by OHA through a robust public process and in collaboration with stakeholders.

CCO accountability metrics will function both as an assurance that CCOs are providing quality care for all of their members and as an incentive to encourage CCOs to transform care delivery in alignment with the goals of HB 3650.

CCO Measurement and Accountability Plan

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

Measurement and reporting requirements

The OHPB recommends that accountability measures for CCOs be phased in over time to allow CCOs to develop the necessary organizational infrastructure and enable OHA to incorporate CCO data into performance standards. Staging of accountability reporting requirements should follow a consistent schedule based on the effective date of each CCO's contract, such as:

- 0-6 months – capacity development
- 6 months - first measurement period begins
- 18 months – first report date

While annual reporting will serve as the basis for holding CCOs accountable to contractual expectations, the OHPB recommends that OHA assess performance more frequently (e.g. quarterly) on an informal basis to facilitate timely feedback, mid-course corrections, and rapid improvement.

Accountability standards, monitoring and oversight

The Board recommends that OHA establish two levels of CCO performance standards: minimum expectations for accountability and targets for outstanding performance. Performance relative to targets will affect CCOs' eligibility for financial and non-financial rewards. CCOs' performance with respect to minimum expectations relates to accountability; subpar performance may lead to progressive remediation including technical assistance, corrective action plans, financial and non-financial sanctions, and non-renewal of contracts. CCOs will be expected to assess their performance, to develop quality improvement plans and goals, and to demonstrate progress toward those goals over time. However, OHA will facilitate the provision of technical assistance to assist CCOs to improve their performance with respect to accountability metrics.

As with the reporting expectations, the Board recommends that accountability standards be introduced over time, e.g.:

- First reporting period - performance reporting without budgetary or contractual consequences
- Second reporting period – expectation of improvement if performance is below standards
- Third reporting period - measurement against benchmarks for minimum and outstanding performance

The OHPB recommends that OHA establish a technical advisory group made up of individuals with health quality measurement expertise and use data from CCOs' first reporting period to establish baselines and will set standards (or benchmarks) for both minimum and outstanding performance using those baselines.

Specific areas of CCO accountability metrics

Based on input from OHPB-sponsored stakeholder work groups, the OHPB recommends that CCO accountability metrics include both core and developmental measures. Core measures will be triple-aim oriented measures, including customer satisfaction, that gauge CCO performance against key health system transformation goals and will be uniform across CCOs. Developmental metrics will also reflect goals of transformation but will require systems transitions and experimentation in effective use; the

subset may include newer kinds of indicators (for which CCOs have less measurement experience) or indicators that entail collaboration with other care partners. The OHPB recommends that minimum performance expectations not apply to developmental measures but that improvement or exceptional performance as defined by the technical workgroup could qualify CCOs for financial or non-financial rewards (see above). CCOs will have some choice among a menu of developmental metrics.

The initial set of CCO accountability metrics and data sources will be established in consultation with the technical group and CMS in early 2012 and will focus on outcomes and system transformation. See Appendix E for examples of potential CCO accountability metrics and an example of how accountability for transformation can be shared across the system.

Annual review of CCO accountability metrics

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

Shared Accountability for Long Term Care

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

Models under consideration for shared financial accountability include:

- Financial incentives and/or penalties linked to performance metrics – applied to the CCO and/or to the LTC system
- Shared risk and/or savings for performance measured against benchmarks related to LTC utilization or expenditures

8. Financial Reporting Requirements to Ensure Against Risk of Insolvency

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

The OHPB recommends that OHA collaborate with DCBS and the Office of the Insurance Commissioner, as required by HB 3650, to review CCO financial reports and evaluate financial solvency. HB 3650 specifies that CCOs should not be required to file financial reports with both the Health Authority and DCBS; which agency is the more appropriate recipient of such report remains to be determined. The following section provides an overview of proposed requirements related to the above items and addresses additional information on organizational structure, corporate status and structure, existing contracts and books of business, and risk management capacities that CCOs shall report.

Audited Statements of Financial Position and Guarantees of Ultimate Financial Risk

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

> "[E]nsure that insurers possess and maintain the financial resources needed to meet their obligations to policyholders. The pursuit of financial soundness begins with the

> initial licensing determination about which insurance companies are admitted to do business in Oregon and continues with ongoing financial reviews of existing companies. The Insurance Code establishes a floor of $2.5 million of capital and surplus for an insurer to be authorized to transact insurance. This floor increases as the company assumes more insurance risk. Capital and surplus is the amount a company's assets exceed liabilities." "Health Insurance In Oregon," DCBS; January 2009; p8

The Board recommends that CCOs submit financial information on the form developed by the National Association of Insurance Commissioners (NAIC). The NAIC form is designed to support the review of health plans and insurers contracting for Medicaid, Medicare, and commercial coverage. Use of the NAIC form will allow for standardization of accountability and solvency assurances across health plans enrolling Medicaid, Medicare, and commercial populations and will address the CMS's interest in having organizations that enroll Medicare beneficiaries regulated by the state's Division of Insurance. The NAIC form includes quarterly and annual audited statements of financial position including reserves, retrospective cash flows, and quarterly and annual statements of projected cash flows. A plain language narrative explanation of the required statements of financial position and statements of projected cash flow will be developed and made publicly available as required by statue.

Financial Solvency

The OHPB recommends that information from the NAIC financial reports be used by financial analysts from DCBS and DMAP and by the OHA Actuarial Services Unit to track the financial solvency of CCOs as they gain (or lose) enrollment over time and build their financial reserves and other risk management measures commensurately. The factors below have been identified as gauges of a CCO's financial solvency; final financial reporting and solvency terms will be negotiated with CMS, which will participate regarding inclusion of Medicare funding for individuals who are dually eligible:

- *Risk-bearing entity*: As required by HB 3650, the CCO will identify whether the CCO itself or some other entity (such as a state or local government agency, or a reinsurer) will guarantee the CCO's ultimate financial risk, in full or in part. In some cases, CCOs may enter into contracts with hospitals, physician groups, or other providers to share in the financial risk (and rewards) associated with the difference between targeted or projected expenditures and actual expenditures. Insofar as these arrangements reduce the risk borne by the CCO itself, other financial solvency requirements may be adjusted.
- *Reinsurance*: Provided through the state or purchased individually by CCOs, reinsurance will act to limit the financial risk of the CCO by capping its risk exposure on either a case-by-case or aggregate basis.
- *Risk reserves*: An adequate amount of liquid reserves to meet fluctuations in claims liability is required of health plans providing commercial, Medicare, and Medicaid coverage in Oregon. Risk reserve requirements for CCOs will be set to reflect the CCO's enrollment level and its mix of covered lives based on rate category.
- *Medical loss ratio*: This is the ratio of expenditures on health care services to total revenue (paid claims divided by total revenue).

- *Size of the organization and risk characteristics*: Total number of insured lives and the risk characteristics across all lines of business will be considered
- *Enrollment level*: The predictability of CCO expenditures and the ability of the CCO to bear risk are reduced at lower enrollment levels. CMS currently requires that Medicare Advantage Plans have a minimum enrollment level of 5,000 beneficiaries. OHPB recommends that CCOs be required to file their actual and projected enrollment levels, by rate category.
- *Organizational liability*: As required by HB 3650, CCOs will be required to file a statement identifying the entity that will be the guarantor of the CCO's ultimate financial risk and any other entities or persons sharing in that risk (in addition to identifying contracting providers bound by risk sharing agreements with the CCO).
- *Real property, investments, and executive compensation*: As required by HB 3650, each CCO will be required to disclose their real property holdings and their 20 largest investment holdings including relative risk of these investments, and the CCO's three highest salary and benefit packages. The combined capital and surplus maintained by comparable insurers will also be considered.
- *Operating budget*: As described below, OHPB recommends that each CCO be required to describe an annual operating budget including projected revenue and investments, projected utilization levels by key categories of service, and projected expenditures reflecting any alternative payment methodologies implemented. This operating budget will serve both to indicate the financial soundness of the CCO and to demonstrate that the CCO has developed its budget to reflect the requirements and objectives of health systems transformation.
- *Administrative expenses*: As required by HB 3650, each CCO will be required to outline, by category, administrative expenses relating to provision of services under its CCO contract and administrative expenses relating to the CCO's (or its holding company's[2] or affiliated entity's) contracts for other populations including Medicare, PEBB, OEBB, and other commercial insurance. A comprehensive understanding of CCO administrative expenses will make possible a more accurate evaluation of the CCO's overall sustainability.

OHA Monitoring and Oversight

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

[2] Oregon statute does not currently require that an insurer licensed by DCBS (or reviewed by the OHA) to provide holding company registration. Such a requirement will be necessary if CCO holding company information is to be effectively reviewed.

Quality, access and financial monitoring

The OHPB recommends that measures for monitoring and oversight in these areas be aimed initially at root cause analysis and assisting the CCO in developing improvement strategies. Steps taken should be are progressive and may include:

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

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

Monitoring of financial solvency

If a CCO's financial solvency is in jeopardy, OHPB recommends that OHA and DCBS act as necessary to protect the public interest. These measures will have two objectives: first, to restore financial solvency as expeditiously as possible; and second, to identify the causes of the threat to solvency and implement measures to prevent such threats in the future. Actions may include:

- Increased reinsurance requirements
- Increased reserve requirements
- Market conduct constraints

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

Public Disclosure of Information

Current DCBS rules require the public disclosure of information pertaining to licensed insurers. OHPB recommends that these rules also apply to CCOs.

CCO Licensure

OHPB recommends that a new licensure category will be created for CCOs by DCBS in collaboration with OHA. The unique requirements and objectives of health systems transformation and the singular nature of the CCO as distinct from: a) commercial insurers, b) OHP Medicaid/CHIP fully or partially capitated physical health care plans (MCOs), mental health organizations (MHOs) and dental care organizations (DCOs); and c) Medicare Advantage plans. A separate licensure category will also facilitate the blend of flexibility and accountability that will be needed for successful implementation of CCOs.

Organizational Characteristics

OHPB recommends that CCOs provide information on corporate status, participation in the Oregon Health Plan, and other contracts:

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

Corporate Assets and Financial Management

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

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

9. Implementation Plan

Transition Strategy

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

- *Financial incentives: Global budget adjustments, annual trend rates, and incentive payments or enhanced federal financial payments, if available, could be structured to support CCOs, providing financial incentives to form the new organization early. This approach provides not only strong incentives and resources for CCOs, but also underscores the urgency and priority of health system transformation.*
- *Enrollment incentives: Building up sufficient enrollment to mitigate risk is essential for CCO start-up. New eligibles and those due for annual redetermination should be automatically enrolled in CCOs. This strategy will need to take in to account the choice and notification of enrollees, including those eligible for both Medicare and Medicaid.*
- *Flexibility incentives: efforts to provide flexibility in service delivery and administration should be directed first and foremost to CCOs.*

Transitional Provisions in HB 3650

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

Implementation Timeline

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

<u>Rules</u>:

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

<u>CCO Applications:</u>

March 2012	OHA will release CCO application, with Letter of Intent
April 2012	CCO applicants will submit applications to demonstrate that they meet CCO criteria to OHA

April-May 2012	OHA will evaluate CCO applications
June 2012	OHA will certify CCOs (CMS will approve CCOs for enrollment of dually eligible)

Contracts:

March 2012	CCO estimated cost submission process defined (including public comment process) and release of CCO Base Cost template
April 2012	CCO applicants will submit notices of intent to contract and, subsequently, base cost estimates
April –June 2012	State to negotiate CCO contracts and budget? (CMS will participate regarding inclusion of Medicare funding for dually eligible)
	April-May: OHA Review and Certification of CCO Rates
	May: Final Review of CCO budget
	June: CCO budget Submitted to CMS
	June: Contract to CCO
	July 1: Effective date of CCO Contract

Implementation:

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

10. Appendices

A. CCO Criteria Matrix (criteria detail)
B. Table of eligibles for CCO enrollment and current managed care enrollment status
C. Program List
D. Overview of CMS design proposal for integration and coordination of health care delivery systems for individuals who are dually eligible for Medicare and Medicaid. (Forthcoming)
E. Accountability framework and example metrics

APPENDIX A: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

This document reflects ongoing OHA/DHS staff analysis of issues relating to the statement of work and certification criteria for Coordinated Care Organizations (CCOs) that will contract with OHA under HB 3650. It will be revised and expanded over the next several months to reflect discussion and input from the External Work Groups appointed by the governor, feedback from other stakeholders, discussion and recommendations from the Oregon Health Policy Board, and guidance from the 2012 Legislative Session. **This is a working document and is for discussion purposes only.**

Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
Governance Structure: **Each CCO has a governance structure that includes:** • **a majority interest consisting of the persons that share the financial risk of the organization** • **the major components of the health care delivery system, and -the community at large, to ensure that the organization's decision-making is consistent with the values of the members of the community**	• CCO clearly articulates selection criteria for governing members and assures transparency in governance—who the decision makers are, how decisions are made and how decision-making is linked with the work of the Community Advisory Council.		• Feedback from the Community Advisory Council • Member experience or satisfaction surveys	
Community Advisory Council: **Each CCO convenes a community advisory council (CAC) that includes representatives of the community and of county government, but with consumers making up the majority of the membership and that meets regularly to ensure that the health care needs of the consumers and the community are being met**	• CCO establishes a CAC grounded in an assessment of community health needs and a process that assures the CAC reflects the diversity of the community. • CCO employs best practices to support engagement and participation of members, including those facing barriers to participation.	• CCO assures collaboration between the CAC and the governing board on policy formulation and other decision-making affecting patient care and health outcomes.	• Community needs assessment results • Attendance of CAC members and consideration of CAC recommendations in Board meeting in minutes	

APPENDIX A: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
<u>Nonprofit Agencies</u>: **The Authority shall consider the participation of area agencies and other nonprofit agencies in the configuration of CCOs.**	• CCO has plans for developing and maintaining linkages between local government agencies and other nonprofit agencies in the configuration of CCOs.			
<u>Dental Care Organizations</u>: **On or before 7/1/14, each CCO will have a formal contractual relationship with any DCO in its service area**	• CCO has a plan for forming contractual relationships with any DCO in its serve area on or before 7/1/14.	• CCO has taken concrete steps towards forming contractual relationships with any DCO that services members of the CCO in the area where they reside on or before 7/1/14. • CCOs will need to ensure network adequacy for dental care providers; provide navigation assistance to access dental care, and make appropriate referrals for chronic diseases related to oral health issues.		
<u>Person-centered Care</u>: **Each member receives integrated person-centered care and services designed to provide choice, independence and dignity**	• Members should be reassessed at least annually to determine whether their care plans are effectively meeting their needs in a person-centered, person-directed manner.		• Patient experience of care data (e.g. CAHPS measures) • Shared decision making measures	
<u>Safeguards for Members</u>: **CCO complies with safeguards for members as described in Section 8, Consumer and Provider Protections,**	• CCO adheres to safeguards for members as described in Section 8 of HB 3650.	• CCO adheres to safeguards for members as described in Section 8 of HB 3650. In addition, CCO supports		

APPENDIX A: Draft Matrix of Suggested CCO Criteria

Based on OHPB Action Plan, Work Groups' Discussions and Other Public Input as of 11/17/11

Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
of HB 3650		members by carrying out (1)(a) – (e) to the greatest extent feasible.		
<u>Patient Engagement</u>: **CCO operates in a manner that encourages patient engagement, activation, and accountability for the member's own health.**	• CCOs will perform an upfront assessment of member's capacity for participating effectively in advocating and coordinating their own care. • CCO demonstrates how it will facilitate activation of its enrolled population, understanding to the greatest extent feasible, how the approach taken will take into consideration the social determinants of health. • OHA may provide a clearinghouse of best practices for CCOs and disseminate best practice information when available.	• CCO provides resources based on member's Patient Activation level (1, 2, 3 or 4). • CCO demonstrates they are training and engaging their providers to facilitate patient and family/caregiver's engagement.	• CCO assesses members' activation levels) • Activation improvement over time: X% of members improving by Y% in Z amount of time	
<u>Member Access and Provider Responsibilities</u>: **Members have *access* to a choice of providers within the CCO's network and that providers in the network:** • **work together to develop best practices for care and service delivery to reduce waste and improve health and well-being of members**	• CCOs must ensure that each member has a primary care provider or primary care team that is responsible for coordination of care and transitions. • Ensure access to primary care where screenings can occur to determine if a higher level of care is needed.	• CCOs will ensure a breadth of providers capable of providing services across the continuum of care with a multidisciplinary, holistic and team approach.	• Community needs assessment results	

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Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
• **are educated about the integrated approach and how to access and communicate with the integrated system about patient treatment plans and health history** • **emphasize prevention, healthy lifestyle choices, evidence-based practices, shared decision-making and communication** • **are permitted to participate in networks of multiple CCOs** • **include providers of specialty care** • **are selected by CCOs using universal application and credentialing procedures, objective quality information and removed if providers fail to meet objective quality standards** • **work together to develop best practices for culturally appropriate care and service delivery to reduce waste, reduce health disparities and improve health and well-being of members**	• Ensure providers are working at the top of their license.			
<u>Member and Care Team</u>: **Each member has a consistent and stable relationship with a care team that is responsible for providing preventive and primary care, and**	• CCO has a significant percentage of members enrolled in patient centered primary care homes (PCPCHs) certified at least as Tier 1	• CCO demonstrates that an increasing number of their enrollees will be served by certified PCPCHs and that those PCPCHs will be moving	• % of members in a PCPCH • % of PCPCHs certified as Tier 3 (highest level) • A delivery system network plan that includes network	

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Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
for comprehensive care management in all settings	according to Oregon's standards. • CCO demonstrates ability to offer enrollees a comprehensive delivery system network with the PCPCH at the center, with other health care providers and local services and supports under arrangement for comprehensive care management.	toward Tier 2 and 3 of the Standards. • CCO demonstrates a comprehensive approach to care management by developing meaningful relationships between PCPCHs, the health care community, state and local government, and community services and supports.	development activities, on-going management, and technical assistance for providers. • Data that identify utilization by provider type with a plan to address shifts in care within the delivery system.	
<u>Holistic Care through Primary Care Homes</u>: **Supportive and therapeutic needs of each member are addressed in a holistic fashion, using patient-centered primary care homes and individualized care plans to the extent feasible**	• CCO develops a process to conduct health screenings for members to assess individual care needs. • Each member shall have an individual care plan for physical and behavioral health care needs, inclusive of social support needs (e.g., community resources and housing). Individual care plans shall consider specific treatment plans from all providers.		• X% of members receive health screen in year 1 • X% of high risk members have individualized care plan in year 1 • % of eligible members have a personalized care plan established within X days of enrollment	
<u>Transitional Care</u>: **Members receive comprehensive transitional care, including appropriate follow-up, when entering or leaving an acute care facility or long term care setting**	• CCO develops plan to address transitional care for members facing admission or discharge from hospital, hospice or other palliative care, home health care, adult foster care, or skilled nursing care.	• CCO has ability to track member transitions from one care setting to another, including engagement of the member and family members in care management and treatment planning. Tracking	• Follow-up after hospitalization: % discharged from inpatient care who have a follow-up visit within X days • Care Transition Measure (CTM-3): 3-item	

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		system may include appropriate follow-up guidelines, alerts, and reporting.	questionnaire measuring quality of patient preparation for transitions (understanding own role; medication reconciliation; incorporation of personal preferences into care plan)	
<u>Navigating the System</u>: **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**	• CCO provides access to non-traditional health workers, and assists members to navigate the health care system and facilitates appropriate linkages to state and local government agencies and community and social support service organizations to capitalize on available resources for different members' needs.	• All CCO members have full support in navigating the health care system and in accessing the full range of services and supports available through state and local government and other community and social support services that may be provided by both traditional and non-traditional health workers.	• Ratio of non-traditional health workers to enrollees • % of members assigned to a non-traditional provider(s) that is appropriate for their needs	
<u>Accessibility</u>: **Services and supports are geographically located as close to where members reside as possible and are, if available, offered in non-traditional settings that are accessible to families, diverse communities and underserved populations**	• CCO has a delivery system network that provides appropriate access to needed health care services close to where members reside that may also include non-traditional settings and community services and supports.	• CCO manages a comprehensive delivery system network based on patient-centered primary care homes and inclusive of non-traditional settings. • CCO identifies underserved populations and addresses their health disparities, adjusting services and settings to match their needs.		
<u>High Need Members</u>: **Each CCO prioritizes working with**	• A substantial percentage of high risk members have an	• CCO develops a system to identify and track high-risk	• Rate of avoidable hospitalizations	

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Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
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	individualized care plan.	members and their outcomes, including avoidable ED visits and hospital admissions. • Provider network capacities are adjusted to reflect changes in the need for and use of preventive services, remedial and supportive care, emergency care, and hospital care.	• Rate of non-emergent ED visits • Measures of patient engagement or patient activation	
<u>Learning Collaborative</u>: **Each CCO participates in the learning collaborative described in ORS 442.210**	• CCO participates in the learning collaborative described in ORS 442.210 that engages state and local government, private health insurance carriers, third party administrators, patient-centered primary care homes, other critical health care providers, state and local government, and community and social support services.			
<u>Patient Centered Primary Care Homes</u>: **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**	• CCO works with participating Patient-Centered Primary Care Homes (PCPCHs) to develop a comprehensive Delivery System Network (DSN) and to assure effective person-centered care planning and coordination which may be evidenced by a plan. • CCO requires their other		• x% of CCOs' primary care network is PCPCH by end of year 1 • x% of primary care network is Tier 3 PCPCH by year 3	

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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.	contracting health and services providers to communicate and coordinate with the PCPCP in a timely manner using electronic health information technology, where available.			
<u>Health Equity</u>: **Health care services…focus on…improving health equity and reducing health disparities** Ensuring health equity (including interpretation/cultural competence) and elimination of avoidable gaps in health care quality and outcomes, as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and addictions status, geography, and other cultural and socioeconomic factors.	• CCO demonstrates an understanding of the diverse communities and health disparities in its service area (e.g. via a needs assessment) and describes an approach to substantially reducing these health inequities over time.	• CCO demonstrates meaningful and systematic engagement with critical populations in its community to create and implement plans for addressing health equity and health disparities.	• Community needs assessment results • A comprehensive community oriented health equity plan.	
	• CCO demonstrates how it will address disparities in the delivery of health care services and in health outcomes (access to care, quality of care, chronic disease management, care coordination, provider communication, etc.) and how they will ensure cultural competence.	• CCO develops long term plans that incorporate innovation over time to substantially reduce disparities relating to the social determinants of health, including race and ethnicity in combination with age, income, gender, and other factors.	• Reduction of unwarranted variations in care and outcomes by race, ethnicity, primary language and other factors.	
<u>Alternative Payment Methodologies</u>: **OHA encourage CCOs to use alternative payment methodologies that:** • **reimburse providers on the basis**	• CCOs will need to move from a predominantly fee-for-service system to alternative payment methods that base reimbursement on the quality rather than quantity of services	• CCOs will effectively implement alternative payment approaches to create incentives for evidence-based guidelines and best practices that will be expected to		

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Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
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**	provided.	increase health care quality and patient safety and result in more efficient use of health care services. • CCOs will build provider capacity to help restructure practices to be able to respond effectively to new payment incentives.		
<u>Health Information Technology</u>: Each CCO uses health information technology to link services and care providers across the continuum of care to the greatest extent practicable	• CCO documents its level of electronic health record adoption and health information exchange infrastructure and capacity for collecting and sharing patient information electronically, and develops a HIT improvement plan for meeting transformation expectations.	• CCO providers have EHR/HIE capacity to send and receive patient information in real time, and CCOs have the analytic capacity to assess patient outcomes of care coordination.	• % providers within CCO that meet Meaningful Use criteria • % of CCO providers who have an EHR • % of e-prescriptions, electronic lab orders and clinical summaries shared electronically • Meeting milestones/goals of HIT improvement plan	
<u>Outcome and Quality Measures</u>: 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	• CCO reports an acceptable level of performance with respect to identified metrics, following a consistent schedule based on the effective date of each CCO's	• CCO reports exceptional performance with respect to identified metrics.	• Patient experience of care • Hospital readmission rates • Access (e.g. time from CCO enrollment to first encounter, and type of	• Data timeliness • Availability of clinical data

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Criteria From *HB 3650*	Initial Baseline Expectations	Transformational Expectations	Examples of Accountability Assessments	Challenges
	contract. • CCO submits APAC data in timely manner according to program specifications.		encounter) • HbA1C control • Etc.	
<u>Transparency</u>: **CCO is transparent in reporting progress and outcomes.**	• CCO provides OHA with detailed quality, efficiency, and outcome data (not aggregate results). • CCO has performance feedback loop to contracted entities and providers. • CCO makes aggregate performance information available to members.	• CCO has system in place to provide timely performance and outcomes data to all stakeholders.		
<u>Best Practices</u>: **Each CCO uses best practices in the management of finances, contracts, claims processing, payment functions and provider networks**	• CCOs will address these subjects in their applications to OHA describing their capacity and plans for meeting the goals and requirements established by HB 3650.		• Annual reports	

APPENDIX B

Oregon Medicaid Caseload for Inclusion in Coordinated Care Organization (CCO) Global Budgets
Includes Managed Care and Fee For Service

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

* FCHP - Fully Capitated Health Plan
PCO - Physician Care Organization

Notes:

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

Staff reference:
09-11 Dec Rebal; includes FFS and Managed Care.

APPENDIX C
Example List of Programs That Could Be Included into CCO Global Budgets

Program	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	1. % of Non-LTC Spend
Physical Health Programs*				
Physical health coverage, including emergency transport, FCHP administrative, hospital reimbursement allowances, FQHC wraparound, and pass through.	Depending on benefit package, includes medical care from a physician, nurse practitioner or physician assistant; hospital care; hospice care; laboratory and x-ray; medical equipment and supplies; emergency medical transportation; physical, occupational and speech therapy; prescription drugs (excluding mental health drugs); vision services and other covered services.	Fully capitated health plans, Physician care organizations	Y	52%
		FFS Only		18%
Dental coverage, including DCO administrative**	Includes basic dental services, urgent/immediate treatment and other services.	Dental Care Organizations	Y	5%
Non-emergency medical transportation	Includes wheelchair van, taxi, stretcher car, bus passes and tickets, secured transportation	Transportation Brokerages & FFS		2%
Citizen Alien Waived Emergent Medical (CAWEM)	Emergency medical services to non-citizens who are eligible for medical assistance except they do not meet the Medicaid citizenship and immigration status requirements.	FFS Only		1%
Citizen Alien Waived Emergent Medical (CAWEM) Prenatal Program	Prenatal care to pregnant women who are currently only eligible for CAWEM Emergency Medical. (Only in select counties; voluntary enrollment only)	FFS Only		<1%
Breast and Cervical Cancer Program - Medical	Provides access to medical care for low-income, uninsured, and medically underserved women diagnosed with breast or cervical cancers	FFS Only		<1%
Behavioral Rehabilitation Services (Leverage)	Services provided by a child-caring agency in a shelter, residential or therapeutic foster care placement setting to remediate psychosocial, emotional and behavioral disorders.	FFS Only		<1%
Targeted Case Management (Leverage)	Assists eligible clients in gaining access and effectively using medical, social, educational, and other services.	FFS Only		<1%

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

APPENDIX C
Example List of Programs That Could Be Included into CCO Global Budgets

Program	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	1. % of Non-LTC Spend
Addictions & Mental Health Programs				
Mental Health Coverage including MCO administrative	A broad range of ambulatory assessment and treatments (based on the prioritized list) of mental health conditions provided in community-based settings by licensed practitioners or non-licensed personnel employed by agencies with a certificate of approval by OHA/AMH.	Mental Health Organizations	Y	8%
		FFS Only		1%
Adult Community Residential Mental Health Services	Mental health services provided in a residential setting.	CMHP		3%
Community adult outpatient MH treatment services, case management, vocational and social services, locating housing, peer delivered services	A broad range of ambulatory assessment and treatments (based on the prioritized list) of mental health conditions provided in community-based settings by licensed practitioners or non-licensed personnel employed by agencies.	CMHP		1%
Addiction health coverage	Ambulatory assessment and treatments (based on the prioritized lit) of substance use disorders provided by licensed professionals or non-licensed personnel employed by agencies.	FCHPS and PCOs	Y	1%
		FFS Only		<1%
Alcohol and Drug Continuum of Care	A broad range of ambulatory services and supports for people who lack health care coverage and require assessment and/or treatment for substance use disorders.	CMHPs		<1%
Adult residential alcohol and drug treatment	Alcohol and drug treatment provided in a residential setting.	CMHP and direct contracts w/providers		<1%
State Inpatient Mental Health Services for Non-Forensic Children	Includes Stabilization Transition Services, the Secure Children Inpatient Program and the Secure Adolescent Inpatient Program.	Residential Providers		<1%
Residential mental health for non-forensic children	Mental health services provided in a residential setting.	MHO plus provider direct billing to DMAP for non-MHO enrolled children	Y	<1%
Youth residential alcohol and drug treatment (OHP carve out)	Alcohol and drug treatment services provided in a residential setting	None - Direct contracts with all providers		<1%
Psychiatric Day Treatment Service for Children	Psychiatric day treatment service delivered in a facility-based setting.	MHO-provider direct billing to DMAP for non-MHO enrolled kids	Y	<1%
Children's Statewide Wraparound	Services and supports for children with complex behavioral health needs and their families.	MHO	Y	<1%
Personal Care 20 Client Employed Provider for People with Mental Illness	Intensive community or in-home supports to assist Medicaid eligible, disabled individuals with activities of community living.	Client employs provider		<1%

APPENDIX C
Example List of Programs That Could Be Included into CCO Global Budgets

Program	Description	Current intermediate entity, if any (ex. Counties, MHOs, FCHPs, etc.)	In Current Cap Rates?	1. % of Non-LTC Spend
Seniors & People with Disabilities	**Descriptions**			
Payment of Medicare premiums for dual eligibles	Medicare premium payments for dually eligible paid by Medicaid	N/A	Y	4%
Cost-sharing for Medicare skilled nursing facility care (day 21-100)	Applicable deductibles, coinsurance, and copayment amounts for dually eligible enrollees	N/A		<1%
OHP Post Hospital Extended Care	Provides a stay of up to twenty days in a nursing facility to allow for discharge from a hospital to a nursing facility	FFS Only	Y	<1%
Public Health	**Descriptions**			
School-Based Health Center Services	Comprehensive primary care clinics that provide physical, mental and preventive health services to school-aged children in a school-based setting.	Local Public Health Authority (LPHA)		1%
Babies First!	A nurse home visiting program for families with babies & young children up to 5, with significant health & social risks. Provides health assessments, aligns community resources, strengthens parenting skills, and improves infant health outcomes.	Local Health Departments		<1%
Maternity Case Management	An education and support program for women with social or health concerns during pregnancy to improve health outcomes.	Local Health Departments (DMAP provides reimbursement for MCM services to a broader community of prenatal care providers not under the public health program)		<1%
Oral Health Dental Sealant Program	School-based prevention program to provide oral health screenings and protective dental sealants for 1st and 2nd graders.	Contracted hygienist		<1%
Oregon MothersCare	County care coordination: pregnancy testing, applying for OHP, scheduling initial medical and dental appointments, providing information about WIC, Maternity Case Management services, and other pregnancy-related resources and services.	LHD, Other community partners		<1%

Appendix E

Potential CCO Performance Measures

Examples Only

- Rate of tobacco use among CCO enrollees
- Obesity rate among CCO enrollees
- Low birth weight
- Breastfeeding exclusivity at 6 months
- Well child visits
- Dental visits (% of members with any visit in past year)
- Wait time for dental visit
- Depression screening
- Alcohol screening (e.g. SBIRT)
- Initiation & engagement in drug, alcohol, and mental health treatment
- Penetration rate for mental health and chemical dependence treatment
- Cholesterol control for patients with CAD
- Cholesterol control for patients with diabetes
- Glucose control for diabetics
- Cancer screening (1 of: cervical, breast, or colorectal)
- Chlamydia screening
- Fall risk screening (older adults)
- Service engagement (% members who received no health services at all in x period)
- Member or patient experience with:
  - Getting needed care & getting care quickly
  - Shared decision making and participation in care planning
  - Care coordination
  - Chronic disease self-management support
  - Primary provider or provider team
  - Overall experience of care
- Primary care-sensitive hospital admissions (AHRQ PQIs)
- ED visits by primary diagnosis (e.g. mental health, substance abuse, dental, other)
- Hospital acquired infection rates
- Medication management (e.g. % discharges where medications were reconciled within 7 days)
- Follow-up after hospitalization (visit within 7 days of discharge for physical or mental health diagnosis)
- Readmission rates (30 day risk-adjusted for hospital and inpatient psychiatric)
- End of life care preferences (e.g. % dual eligibles or age-specified members who have a POLST form on file)
- Health status improvement
- Functional status improvement

Accountability by Level

Illustrative examples for discussion purposes only

Example Domain: Care Coordination

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

Collected by OHA