



**The Woodrow Wilson School's
Graduate Policy Workshop**

**Opportunity for Oregon:
Reforming the Health Care Delivery System
and Meeting the Triple Aim**

Recommendations to the Oregon Health Authority

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List of Abbreviations

ACA	Patient Protection & Affordable Care Act	HHS	Department of Health and Human Services
AEITC	Advance Earned Income Tax Credit	HIPAA	The Health Insurance Portability and Accountability Act
AF4Q	Aligning Forces for Quality	HITC	Health Insurance Tax Credit
APAC	All Payer All Claims Reporting Program	MAC	Medicaid Advisory Committee
APTC	Advance Premium Tax Credit	MBI	Medicaid Buy-In Program
AQC	Alternate Quality Contract	MHQP	Massachusetts Health Quality
BHP	Basic Health Program	MMCO	Medicaid Managed Care Organization
BHPH	Behavioral Health and Physical Health	MNCM	Minnesota Community Measurement System
CAC	Community Advisory Committee	NCQA	National Committee for Quality Assurance
CalPERS	California Public Employees Retirement System	NQF	National Quality Forum
CCM	Coordinated Care Model	OEBB	Oregon Educators Benefit Board
CCO	Coordinated Care Organization	OHA	Oregon Health Authority
CFR	U.S. Code of Federal Regulations	OHP	Oregon Health Plan
CHIP	Children’s Health Insurance Program	OPIN	Oregon Procurement Information Network
CHIPRA	Children’s Health Insurance Program Reauthorization Act	P4P	Pay for Performance
CHQPR	Center for Healthcare Quality and Payment Reform	PCPCH	Patient Centered Primary Care Home
CIVHC	Center for Improving Value in Health Care	PEBB	Public Employees’ Benefit Board
CMS	Center for Medicare & Medicaid Services	PPO	Preferred Provider Organization
CORE	Center for Outcomes Research & Education	Q-Corp	Oregon Health Care Quality Corporation
EASA	Early Assessment and Support Alliance	QHP	Qualified Health Plan
ED	Emergency Department	RFP	Request for Proposal
EITC	Earned Income Tax Credit	SAMHSA	The Substance Abuse and Mental Health Services Administration
EQRO	External Quality Review Organization	SBIRT	Screening, Brief, Intervention, and Referral to Treatment
ESI	Employer Sponsored Insurance	SME	Subject Matter Expert
FPL	Federal Poverty Level	SQAC	Statewide Quality Advisory Committee
FQHC	Federally Qualified Health Center	SSDI	Social Security Disability Insurance
GAO	Government Accountability Office	SSI	Supplemental Security Income
HCTC	Health Care Tax Credit	TPA	Third Party Administrator
HERC	Health Evidence Review Commission	VA	Veterans Affairs

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Executive Summary

Oregon has been working to reform its health care system for over a decade, and the state is capitalizing on the opportunity presented by the recently passed Patient Protection and Affordable Care Act (ACA) to further the Triple Aim of improved quality of care, increased population health, and reduced costs.

As part of a required policy workshop, graduate students from the Woodrow Wilson School of Public and International Affairs at Princeton University approached the Oregon Health Authority about providing analysis and options for enhancing and expanding Oregon's early implementation successes with reform. This report is a culmination of these efforts.

Opportunity for Oregon is subdivided into four sections, each examining a specific aspect of the state's reform effort. The sections provide a brief background for context, delineate key issues to consider, analyze the subject guided by the Triple Aim, and provide issue-specific recommendations. The sections' subject matter and recommendations are provided below.

Section I: Quality Metrics Alignment

Recommendations

- I.1:** Identify a core set of metrics that align across providers, plans, and the Oregon health care exchange to measure system-wide progress towards the Triple Aim.
- I.2:** Designate quality measurement alignment to a multi-stakeholder board and data administration to an independent agency (e.g., Q-Corp).
- I.3:** Work towards simultaneous alignment of metrics and public reporting for consumers across entities.

Section II: The Coordinated Care Model Expansion to the Public Employee's Benefit Board

Recommendations

- II.1:** Undertake a comprehensive analysis and review of Public Employee's Benefit Board population.
- II.2:** Expand utilization of Patient Centered Primary Care Home model as a primary step in the transition to the Coordinated Care Model.
- II.3:** Consider historical spending levels when establishing global budgets.
- II.4:** Develop capacity of the Oregon Health Authority to meet the demands of a global budget model.

Section III: Continuity of Care Considerations

Recommendations

- III.1:** Require transition plans to ease changes in coverage.
- III.2:** Implement the bridge program or expand the Medicaid Buy-In program to close gaps between Oregon Health Plan and Qualified Health Plans.
- III.3:** Employ established principles of behavioral psychology to guide decision-making on Cover Oregon.

Section IV: Behavioral Health and Physical Health Integration

Recommendations

- IV.1:** Maximize Coordinated Care Organization support function of the Transformation Center.
- IV.2:** Encourage information sharing and initial steps for behavioral and physical health integration.
- IV.3:** Address payment and cost issues to facilitate behavioral and physical health integration.

Introduction

Passed in 2009, the Patient Protection & Affordable Care Act (ACA) is a joint federal-state initiative, with provisions to expand health insurance coverage, control costs, and improve the health care delivery system. Further, the legislation provides considerable resources to states pursuing their own health care reform proposals.

Oregon has long been at the forefront of health care reform. Years before the ACA was passed, Oregon's political leaders have sought to establish a health insurance exchange aimed at expanding consumer choice and improving market competition. The ACA provided Oregon with much-needed federal funding and capacity support to implement its unique health insurance exchange, Cover Oregon. More generally, the ACA helped facilitate the advancement of the Triple Aim: improved quality of care, increased population health, and reduced costs.

A group of over 500 stakeholders gathered at the Governor's request and developed Coordinated Care Organizations (CCOs) to transform health care access and delivery to the state's Medicaid population. This model's payment structure, accountability measures, and integrated approach to health care delivery constitute an innovative and promising device for meeting the state's Triple Aim.

The state also established the Oregon Health Authority as the single state agency responsible for purchasing health care for over 850,000 individuals, including Medicaid beneficiaries and public employees, giving it significant purchasing power that can drive change in the health care delivery system. Now, the state may leverage its enhanced buying power to export the Coordinated Care Model (CCM) beyond the Medicaid population.

This report examines four topics addressing components of Oregon's reform efforts: measurement of the health care system's performance, expansion of the CCM, provisions for continuous coverage, and integration of behavioral and physical health care delivery. These topics were selected as key opportunities to enhance and expand Oregon's early implementation successes with reform over the next three to five years. While the sections are linked thematically, they may be considered independently of each other. Each section provides background on the topic, delineates key issues to consider, analyzes the subject guided by the Triple Aim, and provides issue-specific recommendations.

Section I

Quality Metrics Alignment

Background

Dynamic accountability processes are critical to the success of Oregon's delivery system transformation and progress towards realizing the Triple Aim. Quality metrics play a central role in these processes, as better quality care leads to lower costs and better health outcomes. In anticipation of the Coordinated Care Model's (CCM) proliferation in Oregon, the development, monitoring, and reporting of a set of core quality metrics will support efforts to increase the transparency, utility, and alignment of care across the state. While these aligned quality metrics will serve a long-term purpose of providing the framework for the incentive payment system which will support the implementation of a global budget, this chapter focuses on how to align metrics across state entities, rather than how to use aligned metrics to improve care delivery.

This chapter concentrates on four state entities: CCOs, Cover Oregon, the Public Employees' Benefit Board (PEBB), and the Oregon Educators Benefit Board (OEBB). After identifying stakeholder objectives, capacities, and requirements, we evaluate how opportunities to build on existing processes, similarities across state entities, and current sets of quality metrics could be leveraged to create a more aligned system of quality metrics beyond 2014. The chapter concludes with three recommendations based on those findings.

Key Issues

Stakeholders & Audiences: A variety of actors in the health care system have a stake in shaping and influencing the quality metrics used in reform efforts. Quality metrics are central to state policymakers' plans for reform, both as markers of progress and also as vehicles of change in themselves. Metrics can provide information and incentives to consumers, health care providers, and insurers. In other words, each of these groups is both a potential audience for reporting on metrics as well as a target for incentives. These groups all have measurement preferences that do not always align with each other, and as such have an interest in shaping the metrics used going forward. Achieving alignment of quality metrics across the health care system will require continued balancing of these disparate interests.

Data Sources: Any plan to measure quality across a health system is limited by the data available and commonality of reporting standards. Data are collected by various entities for different purposes, and they are often analyzed and reported on by independent organizations. In some cases, the question is not about what *else* to collect, but rather how to improve the utility and functionality of the data sources the state already has at its disposal. Data access also varies; some sources are widely available, while others are restricted or even proprietary. Figuring out how to respect state entities' unique data needs, while promoting rigorous and standardized quality measurement, is a challenge that will require multi-stakeholder partnership.

Data Administration: Collecting, tracking, and reporting on health care quality metrics require significant administrative capacity and coordination. Given the sensitive nature of personal health data and the complexity of quality measurement, stakeholders demand a high bar of subject matter expertise and objectivity in health care quality evaluators. Concerns over confidentiality and data security influence which party is chosen to maintain process ownership. Transparency and accountability also weigh into the designation of administrative responsibility.

Statutory Requirements and Technical Constraints: How might statutory requirements, official guidance, and technical constraints influence Oregon’s transition towards an optimally aligned metrics system? This section summarizes how existing regulations and organizational capacities may constrain entities, in terms of what they can report at what level of detail, and regarding the timeliness with which data can be shared.

Metrics Selection Processes: Each state entity has developed a process for arriving at a set of quality metrics. This section will describe briefly how each of these programs went about identifying potential metrics and then narrowing the measures to a final set. Particular attention is paid to the actors who were involved in the processes, including key stakeholders, state officials, and the general public.

Quality Metrics Alignment: Given the independent sets of quality metrics developed by the OHA, Cover Oregon, PEBB, and OEBC, where are the key opportunities for alignment? Overall, an optimally aligned quality metrics system is one that includes a core set of measures common to all entities and a separate set of program-specific supplemental metrics. The first step in this analysis involves describing the different sets of quality metrics. Next, the discussion identifies similar measures across 7 quality domains where health system transformation is taking place. Focusing on these similarities, this analysis suggests ways to adjust existing metrics, when necessary, to create a set of core metrics. By developing and tracking a common set of quality measures, Oregon will be better able to monitor system-wide progress towards the Triple Aim.

Analysis

Stakeholders & Audiences: Balancing Interests

Each stakeholder in Oregon’s health care system has an interest in shaping how successful reform will be measured by the state going forward. These actors are also potential audiences for the state’s reporting on health care metrics. As audiences, each group has different preferences over the form and content of reporting. For example, the information and detail required for delivery reform and for oversight by state entities are different than those for public reporting and to inform consumers’ decision-making. Each group of actors would like the eventually aligned system to most reflect their own preferences over the preferences of others. Moving toward greater alignment necessarily means balancing what each of these groups of actors want:

- *Policy makers*, including state officials and legislators, want meaningful measurement of progress in health care reform as well as more specific information on any areas that deserve further attention.
- *Care providers*, including physicians, hospitals, and other provider organizations like CCOs, want actionable information on areas in which delivery improvement is both most needed and most achievable. They remain skeptical of report cards, but want clear markers of where they have made progress relative to competitors.
- *Insurers* want to see measures that could set them and their provider networks apart from competitors, but do not want metrics that could potentially make them look bad made public to consumers.
- *Researchers* want increased access to detailed data with which they can examine the quality, costs, and outcomes of health care and contribute to the knowledge base that will continue to inform reform efforts.
- *Purchasers*, including both small and large employers, want information that will allow them to properly evaluate the value of the health plans they could offer to their employees.
- *Consumers* want actionable, easy-to-use tools that support decision-making over health plans, hospitals, doctors, and treatments. They may not seek out or understand information without significant outreach or education. They also value transparency much more highly than any of the other actors.

It is worth noting here that the relevant group of consumers for measuring and reporting on health care may be a subpopulation rather than the full population, and these subpopulations may differ in their preferences

for measurement and reporting. If measures are primarily geared toward a Medicaid population – as is the case for CCOs – the metrics may have less relevance for a privately-insured or an exchange population.

Stakeholder input from all of the groups listed above shaped the development of metrics for CCOs. These metrics also target all of these actors as audiences, with special attention given to state policymakers and the CCOs themselves. Metrics will be reported to the legislature and used internally by the Oregon Health Authority (OHA) to ensure that CCOs are effectively improving care, making quality care accessible, eliminating health disparities, and controlling costs for the relevant populations. They will hold CCOs accountable both through the incentives formed by contractual quality measures and the assurance of public reporting. Accountability is a key feature of the CCM, operating primarily through delivery system and payment innovations that will create feedback loops and mechanisms for holding providers and plans accountable for outcomes. However, accountability also operates through increased transparency, which will be achieved through the reporting of CCO performance data to the public.

Cover Oregon also consulted regularly with consumer groups, business owners, insurance carriers, health professionals, and state partners in the development of metrics for the exchange. However, the intended audience for Cover Oregon's metrics is primarily made up of consumers and small employers. Cover Oregon takes as one of its principal goals increasing consumers' access to information. As such, in addition to metrics for the plans on the exchange, Cover Oregon plans to provide an abundance of resources on health targeted to individuals, including for example information on exercise, nutrition, immunizations, and chronic health conditions. It will also link consumers to services provided by their health plans, like nurse advice lines or preventive wellness programs, and educate consumers on insurance terminology. Finally, the exchange will also allow consumers to meaningfully compare plans using grades, or an overall composite plan score, given to each plan as well as scores for three categories of metrics: preventive care, complex care, and patient experience.

Both PEBB and OEBC have also solicited feedback from a variety of stakeholders, and are primarily oriented toward their respective members. They aim to ensure affordability for employees and to provide members with useful information on plan performance. Members are the principal audience for each of these entities' metrics.

Data Sources: Opportunities for Standardization and Sharing

The four state entities (CCOs, Cover Oregon, PEBB and OEBC) already have a wealth of data at their fingertips. Between metrics for accreditation requirements (HEDIS, CAHPS, HCAHPS, ACES), national studies and surveys (BRFSS, SIPP, NHANES, NHIS, Dartmouth Atlas of Health Care), and state-level collection efforts (APAC, PCPCH, the Oregon Health Study, and plan-specific surveys), there are many tools being used to collect similar data. The establishment of a core set of aligned quality metrics could facilitate the breakdown of enduring information silos, and promote standardized data collection methodology, measurement, and reporting across entities.

The OHA has already identified small ways through which entities can work together to synthesize and avoid duplication of data efforts. For instance with the All Payer All Claims Reporting Program (APAC), the OHA is exploring two methods via which to identify PEBB and OEBC claims: inductively assign PEBB and OEBC "flags" to claims in the database, or rigorously integrate the plans' actuarial datasets into the system. APAC also has tremendous contributory potential to the Cover Oregon rating system. Realizing these concepts through the creation of web-based platforms (versus disparate data servers) will serve to springboard more opportunities that promote ease-of-access and secure data sharing.

Data Administration: Advantages to Independent Aggregation

Because the ultimate goal of quality metrics alignment is to measure care quality consistently throughout the market, there are ease-of-access and sustainability arguments to select an independent entity to manage data alignment across CCOs, Cover Oregon, PEBB and OEBB. Firstly, these state entities are not cleanly housed under a single government authority. Secondly if the state hopes to expand alignment initiatives to include private carriers serving employers and individual insurance customers over the long term, it may be easier to gain private sector buy-in via a public-private partnership structure, statute-mandated authority, quasi-public agency, or non-governmental entity. An independent contractor could also mitigate the technical capacity constraints outlined below. The central administrator must be able to secure and parse data for efficient access across multiple offices and users. The administrator would also be responsible for ensuring data integrity from all public and private contributors.

Several other states have used independent contractors for quality data administration and performance evaluation. The *Minnesota Community Measurement System (MNCM)*, for example, is a collaborative of insurance carriers, providers, consumer groups, and quality improvement organizations that administrates and tracks health care performance statewide. Since 2006, it has been the data conduit, performance evaluator, and accreditor for pay-for-performance (P4P) initiatives in the state (i.e., Bridges to Excellence [BTE]).¹ The organization also hosts the state's multi-stakeholder Measurement and Reporting Committee (MARC) and Hospital Quality Reporting Steering Committee – the bodies in charge of reviewing, recommending, and designing measures, public reporting policies, data collection strategies, and incentive payment systems for the state.^{2 3} Similar to the Oregon Health Care Quality Corporation (Q-Corp), MNCM manages *Health Scores*, a consumer tool that compares clinics, medical groups, and hospitals across a set of process indicators (i.e., use of clinically affective treatments for common conditions), through an arsenal of claims, medical records, and survey data.⁴

In Colorado, the Governor launched the *Center for Improving Value in Health Care (CIVHC)* by Executive Order in 2008, "to identify, advance, support and promote initiatives ... that enhance consumers' health care experiences, contain costs and improve the health of Coloradans."⁵ Originally a public-private partnership, CIVHC has since transitioned to non-profit status and maintains a comprehensive, multi-stakeholder governance structure. The Center currently administrates Colorado's All Payer Claims Database (APCD); it also leads the state's outcomes-based payment reform efforts, engaging stakeholders in goal setting for Colorado's long-term payment reform action plan.⁶

Massachusetts pulls from both internal and independent resources to inform its quality measurement alignment and public reporting efforts. The Center for Health Information and Analysis' *Statewide Quality Advisory Committee (SQAC)* was founded by statute in 2010 to identify and endorse a Standard Quality Measure Set for providers, facilities and medical groups in the state. Committee membership includes representation from many stakeholder groups, including the state Group Insurance Commission (i.e., state employee plans) and Medicaid, but does not currently require representation from the Commonwealth Connector, the state insurance exchange.⁷

Massachusetts also exploits the health care quality data expertise at *Massachusetts Health Quality Partners (MHQP)*, a broad-based collaborative coalition of stakeholders invested in clinical quality and patient experience.⁸ The organization promotes the use of valid, comparable measures to drive system improvement in Massachusetts, and is the state's primary advisor on quality measurement and reporting for *My Health Care Options*, the state-run, web-based, health care quality comparison tool.⁹ MHQP also carried out an innovative partnership with Aligning Forces for Quality (AF4Q) and Consumer Reports to increase the accessibility of its patient experience data. The initiative generated buy-in from the physician community by including them in the report design process, and leveraged Consumer Reports' name and expertise to identify consumers' key interests, and create a user-friendly product.¹⁰

As evident from these examples in other states, an all-inclusive, independent entity – some quasi-public and some private – is commonly trusted to manage large amounts of patient data across multiple populations throughout the market. They are also entrusted to objectively report on provider performance. And even when the reporting platform is state managed, an independent agency often assists the state with technical data administration and reporting.

Statutory Requirements and Technical Constraints: Access Challenges

Beyond entities' needs for population- and audience-specific metrics, there are also statutory and technical constraints to metrics alignment. Although this report does not provide recommendations devising how to address these statutory and technical constraints to data sharing and measurement alignment, it is necessary to acknowledge those challenges.

Some regulations are entity specific. For instance, the CMS 1115 Medicaid Demonstration Waiver requires CCOs to meet (and therefore track) a variety of quality metric benchmarks to receive financial incentives.¹¹ Others apply to the reporting of any patient's health data. In addition to federal HIPAA regulations restricting the use of data with individually identifiable health information, the U.S. Code of Federal Regulations (CFR) 42 Part 2 limits the extent to which substance abuse data can be shared.¹² The Substance Abuse and Mental Health Services Administration (SAMHSA) provides guidance on when substance abuse data can be collected, but the clear interpretation and implications of 42 CFR Part 2 will become increasingly important to Oregon with the development of the APAC and push for behavioral health and primary health care integration.¹³ These and other constraints on data use may also create challenges when trying to conduct precise analyses or reporting on smaller provider groups.

Technical issues surrounding data sharing mainly concern capacity and organizational oversight processes. Easy and timely access to data is a common technical challenge. First, there is the capacity challenge of how to physically share a magnitude of data across staff. For example, an outside contractor houses Oregon's health claims data, and state staff access the data via three different servers. Likewise, internal reports typically need to be peer reviewed before being shared with staff and other entities.¹⁴ Growing demands for data access across state entities with pending metrics alignment coupled with internal needs to track who has access to what are potential hindrances to efficient reporting.

Metrics Selection Processes: Leveraging Stakeholders' Expertise

From the beginning, the selection of objective quality and outcome metrics for CCOs in Oregon was a highly public and collaborative process. Robust community engagement on the part of the OHA ensured that a diverse set of voices were heard in a series of over 100 public meetings. The Metrics and Scoring Committee, preceded by the Transition Metrics and Scoring Committee, was established by Senate Bill 1580 for the expressed purpose of recommending outcomes and quality measures for CCOs. The nine members of the board were selected by the director of the OHA to include representatives from CCOs and the community. This technical advisory group was made up of experts from health plans, health systems, and consumer groups. The committee has been working on building measure specifications, developing benchmarks, designing the accountability and incentive structure, and finalizing the reporting schedule. As of this writing, the committee has produced a final set of incentive metrics for CCOs, tied to their transformation plans, as well as a broader set of metrics that can be revisited to ensure that quality and access are being tracked appropriately going forward.

Cover Oregon has also pursued highly public processes for metrics selection. Board meetings are all public, and the Community Advisory Committee (CAC) provides the exchange with additional input from a small group of citizens. To select quality metrics for the exchange, Cover Oregon contracted with Q-Corp to scan the universe of available measures and select a narrowed set of measures to be presented for public feedback. The emphasis was on selecting metrics that were most relevant, could be aligned with those of the CCOs, and

were already being collected so that no new measures would need to be used in the first year of reporting. Q-Corp researched measures from the National Committee for Quality Assurance (NCQA) and the Metrics and Scoring Committee, and provided Cover Oregon with a set of principles to apply to the metrics selection process – including potential for both improvement and alignment. This methodology and set of selected measures were presented to stakeholders for feedback in a variety of settings and forms, and Cover Oregon incorporated changes from this input into the set of metrics to be used going forward.

PEBB and OEBC, on the other hand, have tracked and reported on performance metrics prior to the existence of either the Metrics and Scoring Committee or Cover Oregon. Both boards continue to revisit and revise their metrics through largely independent processes. OEBC does so through the Strategies on Evidence and Outcomes Workgroup, and PEBB, through their RFP Performance Subcommittee.

The selection processes described above have been successful in selecting metrics that best serve the respective goals and priorities of CCOs, Cover Oregon, PEBB, and OEBC. They have also effectively engaged key stakeholders and in doing so generated buy-in from important groups. Alignment of metrics moving forward will require working with these already existing structures to advance their common goals.

Quality Metrics Alignment: Identification of Core Metrics

The OHA (CCOs), Cover Oregon, PEBB, and OEBC have developed three independent sets of quality metrics to measure progress towards improved health care quality, lower costs, and better health outcomes. As discussed above, the differences between these sets of metrics can be explained by regulatory requirements, technical constraints, data limitations, and stakeholder priorities, among other things. However, similarities also exist, creating an opportunity to develop a common set of core quality metrics that can be monitored consistently across Oregon beginning in 2015. The purpose of this analysis is to work towards aligning quality metrics by identifying a common set of core measures. These core metrics – measured at the same time and in the same way – could enable Oregon to evaluate system-wide progress towards delivery system transformation.

To identify opportunities for alignment, this analysis focuses specifically on the core measures either previously selected or under consideration by the OHA, Cover Oregon, PEBB, and OEBC. As of December 2012, the OHA reached an agreement with the Centers for Medicare and Medicaid Services (CMS) on a set of accountability metrics to monitor CCOs as part of the Section 1115 Demonstration. These 33 metrics align with existing state and national quality measures. Specifically, 16 of the accountability metrics align with the CCO Quality Pool metrics. There is also significant overlap between the accountability measures and the CMS Adult Medicaid Quality Measures and CHIPRA Measures.¹⁵ Cover Oregon selected a set of 13 measures to monitor exchange-related activities. These metrics were drawn from NCQA-recommended measures for health insurance exchanges, CMS starter sets, and measures considered by Q-Corp and the OHA.¹⁶ Finally, the quality measures under consideration by PEBB and OEBC include a set of core measures, a set of supplemental measures, which allows entities to monitor issues of importance to their members or service area, and a set of developmental measures that are being tested for feasibility and validity.¹⁷

To identify similarities, the core measures that each entity plans to track were organized under 7 domains, which are listed below. These domains summarize key areas where health system transformation is occurring. Put broadly, there is diversity in the domain focus across entities. While the 33 measures tracked by CCOs are roughly evenly divided across domains, there is a slight concentration of measures in the areas of hospital care coordination, chronic disease management, and behavioral health. Cover Oregon pays close attention to patient experience: 4 of the 13 core measures the exchange will monitor have to do with patient satisfaction. PEBB and OEBC, on the other hand, tend to focus on the areas of primary care and prevention.

To measure system-wide change, at least one metric was selected from each domain. In some cases, the

chosen metric aligns exactly across entities. In other instances, a slight adjustment can be made to the measure to achieve alignment. The recommended adjustments, discussed below, are based on the following considerations: (1) whether the measure is broadly accepted and meets standard scientific criteria for reliability and face validity – e.g. National Quality Forum (NQF) measures; (2) whether the adjustment only requires a minimal change to the metric; and (3) whether the measure is currently collected or reported by Q-Corp. Taken together, the following measures could make up a core set of quality metrics common across all health care entities in Oregon.

- **Domain 1 - Primary Care:** To monitor improvements in primary care, all entities plan to measure changes in well-child visits. CCOs and Cover Oregon will specifically track well-child visits in the first 15 months of life (NQF #1392). This metric is also collected and publicly reported by Q-Corp.
- **Domain 2 - Patient or Member Experience:** All entities will track one or more responses to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan survey. As part of the CCO Quality Pool Metrics, CCOs will report two CAHPS composites: access to care and satisfaction with health plan customer services. Likewise, 4 of the 13 metrics that will be monitored by Cover Oregon are CAHPS survey questions, including access and measures of health plan satisfaction. Finally, PEBB and OEBC will track survey questions that measure whether members are getting needed care and getting care quickly, as well as the member's overall experience of care. To achieve alignment, the common set of core metrics could include the composite CAHPS survey question that measures access to care, an important issue for all entities.
- **Domain 3 - Behavioral Health:** To measure improvements in behavioral health and progress towards behavioral health and physical health (BPHP) integration, all entities plan to monitor alcohol or other substance misuse. CCOs and Cover Oregon will track the Screening, Brief Intervention and Referral to Treatment (SBIRT) indicator, which describes an “integrated, public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders.”¹⁸ BPHP integration may become a system-wide focus area as the CCM takes hold in Oregon. In addition to alcohol and substance misuse, depression screening is another indicator monitored by all entities. CCOs plan to report on a measure that not only tracks screenings for clinical depression but also the inclusion of a follow-up care plan (NQF #0418).
- **Domain 4 - Prevention:** All entities intend to measure cancer-screening rates. CCOs and Cover Oregon will report on cervical, breast, and colorectal cancer screenings. To align with PEBB and OEBC, the core measures could select one of these screening rates and track it consistently across entities. Additionally, all entities plan to screen for heart disease. Cover Oregon will specifically track the percentage of patients aged 18 to 75 with a heart condition that received a cholesterol test within 1 year after being treated for a heart attack or other heart condition. CCOs, PEBB, and OEBC will report high blood pressure through blood pressure screenings (NQF #0018), but they could consider tracking cholesterol screening, which is currently reported publicly by Q-Corp.
- **Domain 5 - Chronic Disease Management & Improved Wellness:** Changes in diabetes care and control indicates progress in chronic disease management and wellness. Specifically, CCOs will report the HbA1c test (NQF #0057) and LCL-C screening (NQF #0063), while Cover Oregon, PEBB, and OEBC will monitor the percentage of patients who receive appropriate, diabetes-care annual screenings (e.g. eye exam, blood sugar screening, etc.). To achieve alignment across these diabetes care measures, Cover Oregon, PEBB, and OEBC could consider measuring LCL-C screening rates, another metric currently collected and publicly reported by Q-Corp.
- **Domain 6 - Hospital Care Coordination:** To evaluate changes within this domain, 3 measures were identified for the common set of core metrics. First, CCOs, PEBB, and OEBC will report follow-up care received after hospitalization. CCOs could consider tracking follow-up care received for both mental care and physical care, like PEBB and OEBC. Cover Oregon will need to begin measuring follow-up care for

physical and mental health services to achieve alignment in this focus area. Second, CCOs, PEBB, and OEBC will track hospital readmission rates. CCOs have specified that they will track all-cause readmission rates (NQF #1789). To align with the other entities, Cover Oregon would need to broaden its hospital care measure to include readmission rates. Additionally, all entities track hospital usage or overuse. CCOs will report the total emergency department (ED) usage and ambulatory care utilization (i.e. visits per 1,000 members). PEBB and OEBC will measure primary care-sensitive hospital admissions. Cover Oregon will track potentially avoidable hospital admissions and ED visits, a metric currently measured privately by Q-Corp. To reach an aligned overuse or avoidable use metric, each entity could track the rate of avoidable hospital admissions.

- **Domain 7 - Maternal and Prenatal Care:** CCOs and Cover Oregon intend to monitor the timeliness of prenatal care (NQF #1517). To create an aligned metric within this domain, PEBB and OEBC could consider tracking this indicator in the future.

A key achievement of alignment will be to provide state entities with the guidance and tools they need to identify and track the metrics most relevant across all Oregonians as well as within their own populations of interest. Therefore, in addition to these core metrics, each entity will need to continue monitoring supplemental metrics to track progress towards program-specific objectives. Since the population of consumers purchasing insurance through Cover Oregon, and patients insured by PEBB and OEBC plans (and their targeted benefits) will be characteristically different from CCO patients and plan offerings in initial years, it is essential that entities continue to track measures specific to the population of interest.

Recommendations

Recommendation I.1: Identify a core set of metrics that align across providers, plans, and the Oregon health care exchange to measure system-wide progress towards the Triple Aim.

To harmonize quality metrics, the OHA should allow an independent entity to track a limited number of core quality metrics beginning with CCOs, Cover Oregon, PEBB, and OEBC. A common set of metrics will enable Oregon to evaluate changes in health care quality, outcomes, and costs across the state. In addition to these core metrics, each entity should continue to track an additional set of program-specific measures to monitor progress towards independent program objectives.

Based on a comparison of quality metrics selected by each entity, a set of common core metrics was identified. For most of the measures listed below, CCOs, Cover Oregon, PEBB, and OEBC are either reporting the exact metric or a similar measure that could be adjusted slightly to achieve perfect alignment. These proposed metrics could serve as a starting point for discussions about ways to develop and monitor a core set of aligned quality metrics common to all entities.

- **Primary Care:** Well-child visits (NQF #1392).
- **Patient or Member Experience:** CAHPS health plan survey “Access to Care” Composite.
- **Behavioral Health:** (1) Screening, Brief Intervention and Referral to Treatment (SBIRT), and (2) Depression screening and follow-up plan (NQF #0418).
- **Prevention:** (1) Colorectal, breast, or cervical cancer screening, and (2) Cholesterol test.
- **Chronic Disease Management and Improved Wellness:** LCL-C screening (NQF #0063).
- **Hospital Care Coordination:** (1) Follow-up after hospitalization for physical and mental health diagnosis, (2) All-cause readmissions (NQF #1789), and (3) Potentially avoidable hospital admissions.
- **Maternal and Prenatal Care:** Timeliness of prenatal care (NQF #1517).

Recommendation I.2: Designate quality measurement alignment to a multi-stakeholder board, and data administration to an independent agency (e.g., Q-Corp).

For reasons stated above, an optimally aligned metrics system is often facilitated by an independent administrator that assumes ownership over the data collection and reporting processes. Given the technical constraints and existing capacities of state entities, Q-Corp, or a similarly situated entity, should assume responsibility for aggregating and reporting on the core set of quality metrics.

Two possible ways to designate the task of selecting *core* metrics are recommended. In either case, the four entities (CCOs, Cover Oregon, PEBB, and OEBC) would maintain their respective boards and committees for selecting program- and population-specific metrics. One approach could assign the metric selection process to a new state-run, and likely statute-mandated, committee comprised of representatives from the four entities. As mentioned before, because these entities are not all housed under the OHA (i.e. Cover Oregon), it may be advisable to create the committee outside of the standing authorities. The committee would also provide the OHA with the opportunity to engage the Department of Consumer and Business Services in the initiatives informing which quality measures are publicly reported.

Alternatively, Q-Corp's existing Board of Directors could be expanded to include Cover Oregon membership. Board membership already includes key Medicaid [CCO], PEBB, and OEBC leaders.¹⁹ The organization's Measuring and Reporting Committee would then be charged with aligning metrics, similarly to how the Committee already does for Q-Corp's provider-access-only database and *Partner for Quality Care* comparison tool.

Many stakeholders in Oregon uniquely trust Q-Corp as a data manager and objective reporter. Q-Corp already manages administrative claims from the majority of the Medicaid (71 percent) and commercially insured (75 percent) patients in Oregon.²⁰ Most recently, Q-Corp was one of only four organizations selected nationwide to be a Certified Qualified Entity by CMS and receive Medicare claims data.²¹ As noted in the OHA's December 2012 release of Oregon's Accountability Plan and Expenditure Trend Review, Q-Corp has already been awarded the integral role of external quality review organization (EQRO) in CCO measurement strategy – taking on data cleaning, analysis, third party validation, and reporting responsibilities.²² Given Q-Corp's Board already includes CCO representation and its database will have access to CCO patient claims, the barriers to making Q-Corp the central data conduit across all four entities should be relatively low.²³

Beyond the challenge of integrating Cover Oregon representation into the Board, Q-Corp's representative governance structure, its Measurement and Reporting Committee's expertise in measurement selection processes, and its reputation as a trusted data manager, make it a strong candidate to administrate the alignment and management of quality metrics across state entities and, perhaps, be the evaluative mechanism for future P4P initiatives in the state.

Were Q-Corp not selected as administrator, Oregon should seek out partnership with a well-respected, non-partisan organization which:

- Has a track record in managing large amounts of sensitive data,
- Has experience collaborating with, and soliciting buy-in from, diverse public and private stakeholder groups,
- Takes an innovative approach to consumer reporting and education to meet a broad spectrum of consumer needs,
- Supports nimble data systems that will allow Oregon's measurement processes to transform dynamically with changing needs, and
- Possesses the reputational legitimacy and strategic capacity to present objective evaluations of health care quality to a wide range of audiences.

Metrics alignment provides Oregon with an opportunity to leverage its wealth of public and private resources into a data management and reporting system that is as technically robust and secure as it is accessible and collaborative.

Recommendation I.3: Work towards simultaneous alignment of metrics and public reporting for consumers across entities

As the state works toward metrics alignment, the public reporting efforts of Cover Oregon, CCOs, PEBB, and OEBC should also be brought into alignment. In accordance with CMS requirements, the OHA will be publicly reporting all selected CCO measures online to constituents at various levels – informing consumer choices, advancing transparency in the health system, and increasing access for providers, plans, and consumers. Drawing on the work of Cover Oregon and Q-Corp, the OHA should work to develop public reporting for consumers that is consistent across entities, useful, and effective as one part of an overall strategy to improve health care.

Moving forward toward this goal, the OHA should be especially mindful to present streamlined information to consumers. As a stakeholder group, consumers are perhaps the least literate in health care measurement and reporting. With CCOs, Cover Oregon, PEBB, OEBC, Quality Corp, and other organizations all interested in reporting to consumers, consumers could be faced with duplicative or even contradictory messages from a number of different sources. In addition, consumers will have a variety of access points to that information. Given this, information should be presented in a consistent manner and such that consumers can be easily directed to the appropriate source of information from wherever their first point of access is.

Of the relevant actors in the health care system, consumers have been perhaps the slowest to take up and use available reports on health care quality. While consumers may be the most difficult to reach and also have minimal direct impact on delivery transformation, their informed choices could help to drive successful reform in Oregon. Informed consumers are more likely to choose high-quality care and public reports that affect a provider's public image can motivate them to improve to protect their reputation. Consumer use of public reporting could thus encourage providers to improve their quality of care at lower cost.

Public reporting to consumers should be seen as a tool to support all of the transformation efforts in the state, including metrics alignment. While reporting on progress to CCOs and the state are at the heart of reform efforts in Oregon, public reporting also has an important role to play. CCOs, for example, have a history in the state as existing providers, and have a certain amount of inbuilt inertia as a result. Any organization, however, reacts strongly to negative press, which makes effective public reporting an important element of reform. Consumers are also key stakeholders for CCOs, Cover Oregon, PEBB, and OEBC. As such, their support could facilitate the alignment of metrics across entities.

Section II

The Coordinated Care Model Expansion to the Public Employees' Benefit Board

Background

Oregon's health care delivery system was characterized by increasing costs, a limited ability to integrate patient-centered care models, and varying requirements from private and publicly purchased health plans, resulting in differing performance measures, and increasing costs. As part of its Aim High plan, the state endeavored to alter its organizational structure and better align the state's health care delivery system. In July 2009, House Bill (HB) 2009, Oregon's health reform bill established the Oregon Health Authority (OHA). OHA is the single state agency responsible for purchasing health coverage for over 850,000 individuals, including Medicaid beneficiaries, public employees, teachers, the high risk pool, and the state's premium subsidy program. As such, OHA is now responsible for purchasing coverage for one in four Oregonians, giving it significant purchasing power that can drive change in the health care delivery system.

Increasing general fund pressures contributed to the state's efforts to explore ways to improve efficiency, value, and health outcomes. To this end, the CCM "grew out of recognition that the services people need are not integrated, leading to poorer health and higher costs."²⁴ At the core of this new model are community-based organizations that are governed by a partnership between those sharing in financial risk, providers of care, and community members.

In contrast to episodic-based payment, the CCM establishes a single global budget per CCO that grows at a fixed rate, and where reimbursements are based on outcomes, not volume of care. The global budget seeks to create greater budget predictability for the state and stimulate cost savings through integrated care and enhanced service coordination between primary care, inpatient, outpatient, and behavioral health.

Global budgets are initially set using revenue/expenditure targets and then will be increased at agreed upon rates rather than historical trend. In order to establish global budget rates, OHA will estimate a base cost of providing care using reliable cost data from potential CCOs while addressing actuarial soundness, CCO viability, and access to appropriate care. This cost data will indicate the lowest rate a CCO can accept in their "base region," based on current population, geographic coverage and benefit. OHA will use the CCO Base Cost Template as the foundation for the CCO capitation rates.

For the Medicaid program, CCO global budgets will be designed to cover the broadest range of funded services for the most beneficiaries possible. Global budgets will include services that are currently provided under Medicaid managed care in addition to Medicaid programs and services that have been provided outside of the managed care system. This approach will enable CCOs to fully integrate and coordinate services and achieve economies of scale and scope with the necessary flexibility to dedicate resources towards the most efficient forms of care.

This chapter will identify key issues and concerns as Oregon considers options for expanding the CCM in the PEBB environment. In addition, this paper will provide examples from California and Massachusetts that

may inform policy and program decisions. Lastly, this chapter will outline recommendations to better inform the potential expansion of the CCO model into the commercial market.

Key Issues

National Demographics and Health Status of Civil Servants: Unfortunately, there is no central data warehouse containing key health indicators and demographic information specific to all civil service employees at the federal, state, and municipal levels. However, data collected by the U.S. Census Bureau, the Office of Personnel Management, and the Department of Labor provide some insight into a few important demographic characteristics of public sector employees. Understanding demographic and health status trends in Oregon, and how they differ from national trends, is key to designing and implementing an effective health care delivery system in Oregon.

Demographic of Oregon Public Sector Employees: A 2007 study by the National Center for Biotechnology Information, an office within the National Institutes of Health, examined differences in health and health behaviors between Oregon state employees and their private sector counterparts.²⁵ The study found that state employees, despite having greater access to health care, had a lower prevalence of healthy weight and higher prevalence of obesity and diabetes. Additionally, Oregon state employees were less likely to meet physical activity recommendations and self-reported lower status levels of health. These public sector characteristics will prove increasingly important as Oregon continues to overhaul its health care delivery system.

PEBB and the CCM: PEBB is a labor-management board within the Health Programs Division of the OHA and is responsible for managing the insurance benefits program for approximately 134,000 Oregon state employees and their dependents.²⁶ Through its public deliberations, PEBB determines the design of health insurance plans available to state employees, including the breadth of services and programs, levels of coverage, types of benefits offered, enrollment eligibility, and payment structures.²⁷ As a self-insured plan, PEBB is responsible for collecting and funding a pool of premiums and paying all health care claims.

PEBB is composed of eight voting board members, two of whom are ex-officio members, and six who are nominated by the Governor and confirmed by the Oregon Senate. Four of these members represent state agency management and four represent non-management public employees. In addition to the voting members, the board also contains two non-voting advisory members who represent the state legislature. PEBB members meet publicly every month to make decisions about the program while PEBB staff members are responsible for implementing board decisions. Additionally, the PEBB staff is responsible for the purchasing and contracting of benefit plans, managing enrollment and financial data systems, administering benefits consistent with governing rules, and communicating with both the state employers and beneficiaries.²⁸

Of the state employees and their dependents, 85 percent of the 134,000 beneficiaries have coverage through a self-funded Providence Health Plan, a preferred provider organization (PPO), while the balance are covered by two HMO-like plan designs available via Kaiser and Providence Health. PEBB also offers a number of optional benefits, such as extended life insurance plans, disability insurance, accident insurance, and long-term care insurance.

As specified under Division 5 of the PEBB charter, the Board is responsible for obtaining the benefit plans for state employees and their dependents, and Oregon law gives the Board sole authority to select contractors and procure benefits and services for eligible employees.^{29,30} The procurement process begins with PEBB issuing a Request For Proposal (RFP) using the Oregon Procurement Information Network (OPIN) indicating that it intends to contract for benefits. The RFP includes a detailed description of the requested benefits or services and invites qualified prospective contractors to apply.³¹ After prospective contractors

provide a proposal presenting their credentials and their capacity to meet the request, PEBB evaluates each proposal and awards the contract.

PEBB represents an early opportunity to translate the CCM into the commercial market. Structural and policy challenges for the PEBB Board are as follows:

- *State employee labor unions* – the PEBB Board recently announced a one-year delay in its 2014 Request for Proposal (RFP). The PEBB Board recently voted to delay the 2014 RFP for a year. While the Service Employees International Union (SEIU) has voiced support for the CCO concept and its potential for member cost savings and improved outcomes, it has stated that continued oversight and accountability is imperative. Delaying the RFP allows OHA to further develop CCOs, garner lessons learned in implementation for the Medicaid population, and allows for the Board to develop an RFP with specific goals and strategies. In addition, it allows state employees an opportunity to provide input into the organization and structure of health plan benefits.
- *Self-funded versus fully-funded* – in order to implement the CCO model and obtain cost savings, will PEBB need to have a fully-funded option? In addition, if self-insured is maintained, what levers does the state need or have, as a purchaser, to motivate payers to incentivize providers?
- *Third Party Administrator (TPA)* – related to the issue above, if the state remains self-insured, how will the relationship between the TPA and the state change? How will shared savings be implemented in a TPA model?
- *Growth rates of global budgets* – What would a reasonable per year growth of the cap be? What growth rate would create incentives and improved outcomes? How would savings be calculated and negotiated?

Analysis

Self-funded versus fully-funded and role of Third Party Administrators: Adapting the Model

Since 2006, PEBB has used self-insured regional medical and dental PPO plans and, since 2010, the statewide medical PPO has been self-insured. At this time, 85 percent of PEBB members are in a self-insured plan. As such, for the vast majority of members, PEBB is responsible for collecting and funding a pool of premiums and paying all health care claims. In contrast, in its fully insured option, PEBB pays all or part of the premium to an insurer, and the insurer pays claims from the pool of premiums it collects from everyone it insures. PEBB currently contracts with a Third Party Administrator (TPA) for benefit administration functions.

Two critical issues concerning the potential implementation of a CCM by a self-insured purchaser are: incentivizing cost reductions among the different actors; and distributing health care savings back to CCO participants. First, while the CCM gives greater accountability to providers, self-funded employers are at risk for the health care costs of their employees. PEBB will need to identify ways to ensure providers' performances are appropriately incentivized to deliver cost effective services. Further, it is important to note that in 2010, facing a projected 16 percent premium increase, PEBB voted to self-insure the statewide medical PPO. As such, if PEBB were to return to fully insured status, it would be important to evaluate whether savings would be larger than premiums.

Second, if the system generates any savings, how will the purchaser, in this case PEBB, retain and distribute savings accordingly to its partners, and what levers does PEBB have or need to motivate payers to incentivize providers? In this case, a shared savings model may be useful. If a health care system or provider reduces total health care spending for its patients below the level that the payer and provider have negotiated, the provider

is rewarded with a portion of the savings. For PEBB, the Board will need to identify reward for the payer/Third Party Administrator, who in turn incentivizes providers to improve outcomes and reduce costs.

As discussed in a recent paper on payment reform and shared savings, the Center for Healthcare Quality and Payment Reform (CHQPR) points to arrangements and structures in other industries. Specifically, CHQPR notes that in other industries, “bankers and investors commit upfront capital to companies which present a business plan showing how that capital will be used to generate a financial return-on-investment (ROI). A similar approach is needed in the health care industry: if a provider can present a business for generating savings for a payer, the payer should commit a portion of the expected savings as an upfront payment to enable the provider to carry out the plan.”³² For a purchaser-payer-provider relationship, purchasers could provide an upfront reward pool for health care costs and outcomes targets for an entire population and if the payer and providers perform better than the targets, they will receive certain bonus or shared savings between the purchaser and payer.

In the California pilot ACO discussed in the following section, while the California Public Employees Retirement System (CalPERS) offerings are fully insured, this represents an example of the use of a global budget methodology in the commercial sector. In addition, in Massachusetts’ Blue Cross Blue Shield Alternate Quality Contract (AQC), commercial entities are also participating in their global budget arrangement.

Global payment: A Promising Method for Meeting the Triple Aim

In Oregon’s Medicaid program, the global budget, which integrates previously siloed funding streams, represents the total cost of care for all services for which CCOs are responsible and held accountable for managing, either through a capitated per member per month payment or through payment for outcomes. For the PEBB plans, the Massachusetts’ AQC and the global budget CalPERS pilot show that in commercial plans, a global budget payment structure may improve outcomes, enhance quality of care, and reduce the growth of costs, thus providing lessons for implementation in Oregon.

In 2009, Blue Cross Blue Shield of Massachusetts started to utilize a population-based global budget coupled with significant financial incentives based upon performance on a broad set of quality measures. In the AQC model, budgets are based on historical spending and are coupled with a system of performance bonuses based on quality that is not dependent on achieving the global budget targets. In addition to caring for 665,000 HMO members, the AQC includes over three-quarters of its overall network of contracted primary care providers and specialists.³³ It is also important to note that there are commercial employers within this population.

A recent evaluation of cost and quality performance produced promising results. The Harvard study showed that participating physician groups reduced the rate of increase in health care spending by 3.3 percent in the program’s second year, up from 1.9 percent in its first year, thus averaging 2.8 percent. As noted in the study, “the aim is not to reduce the absolute level of spending, but rather to reduce growth in spending.” In the area of *quality*, the AQC members improved in preventive services and management of chronic diseases and fared better than non-AQC participants. In addition to controlling for the growth of budgets and improving health outcomes, another concern of different payment models is the unintended consequence of creating financial incentives for providers to withhold care to minimize costs. As such, Blue Cross established quality incentive payments of up to 10 percent of the total per member per month payments.

It is important to note relevant structural issues relevant that make it feasible for global payment mechanisms in Massachusetts. Eighty percent of commercial enrollment is dominated by three non-profit health plans. Massachusetts also has large organized health systems with electronic health records. Moreover, patients are used to obtaining referrals from primary care physicians due to the state’s long history with managed care. At

this time, AQC's are only for members with managed care coverage. Together, these factors have provided the environmental foundation for payment reform.

In 2010, Blue Shield, in partnership with Hill Physicians Group, started a global budget pilot in the Sacramento region for 41,000 CalPERS employees and dependents enrolled in a Blue Shield health maintenance organization. The pilot established a global per member per month target amount for the cost of health care. As a result of the partners' agreement to reduce the growth in the cost of health care to 0 percent in the first year, CalPERS received an immediate premium credit of \$15.5 million. An evaluation by Millman concluded that health care costs for CalPERS members in the pilot were \$393.08 per person per month in 2010, a 1.6 percent decrease from the 2009 baseline amount. In contrast, for CalPERS members not in the pilot, costs were \$435.94 per person per month, or a 9.9 percent increase from 2009 for that group. In addition, initial outcome findings showed that inpatient days for CalPERS members in the pilot decreased 12.1 percent, hospital readmissions within thirty days of discharge also fell 15 percent, from an already low 5.4 percent of cases to 4.3 percent, and extended hospital stays - those of twenty days or longer - fell by 50 percent.³⁴

As seen in the California model, key elements of success included effective alignment of incentives, easily identifiable improvements, and ease of implementation. Alignment of incentives tied care delivery and cost containment strategies to agreed-upon quality and outcome metrics, health care costs, and member utilization. "The global budget approach facilitates a high-level perspective and lets partners quickly identify clinical and cost 'hot spots' where opportunities exist for the greatest improvement."³⁵ This perspective allows for partners to improve health outcomes by reengineering clinical practices. Lastly, payment for services and reimbursements on the ground did not change; as such, no changes needed to occur for any systems of payment to providers.

Recommendations

Recommendation II.1: Undertake a comprehensive analysis and review of PEBB population

Identifying strategies for improving program effectiveness and reducing costs requires an exhaustive review of the target population to identify who and what are driving costs. With deep analyses, PEBB and its partners will be able to better understand the population's cost drivers and develop interventions based on clinical best practices to address those costs.

In CalPERS' pilot, a health care cost team was developed and reviewed clinical operations, finance, data analytics, marketing, contracts, and legal issues. From this team, specific strategies including improving information exchange, coordinating processes such as discharge planning, and reducing pharmacy costs were identified as cost drivers within CalPERS' Blue Shield population. Moreover, at its foundation, a review is an opportunity to think about using data in a different way beyond premium setting and cost setting. In addition, stakeholders could be included in this review to ensure transparency and member engagement.

Recommendation II.2: Expand utilization of Patient Centered Primary Care Home model as a primary step in the transition to the Coordinated Care Model.

Identification of primary care physicians for beneficiaries is a key element of successful global budget models because it allows for direct payments to the appropriate group. At this time, 34 percent of PEBB beneficiaries are in a Patient Centered Primary Care Home (PCPCH). PEBB could explore, as an interim step, expanding and providing incentives to beneficiaries to choose a PCPCH. PCPPHs are accountable to the community they serve and organize and coordinate care around patients, working in teams and coordinating and tracking care over time. As such, this could be a step towards expanding the Community Care Model, the central role of PCPCHs in CCOs.

Recommendation II.3: Consider historical spending levels when establishing global budgets.

It is important to note that in both examples the initial per capita cap is based on historical spending. Compared to other attempts with capitated plans, Massachusetts' AQC based the initial global budgets on the amount the group spent for the same population in the prior year. A rate of increase was built from that foundation and declines from year to year. In the end, in order to be successful, the group has to use its budgeted dollars more effectively to produce better quality and outcomes, and to slow its rate of spending growth. Initial results from Massachusetts and California's global budget programs showed growth rates between 1.9 and 3.3 percent.

Recommendation II.4: Develop capacity of the OHA to meet the demands of a global budget model.

In both California and Massachusetts, data and supporting ongoing technical assistance continue to be key in supporting change. In addition, as SEIU stated that given PEBB's delay for the 2014 RFP for health benefits, oversight and accountability are critical to ensuring the health benefits and premium costs for its members. As payment reform models are pursued, it is important for the OHA to outline an office architecture dedicated to tracking health care costs, service provision, cost containment strategies, and other quality indicators. This entity could be responsible for overseeing state health care spending, evaluating specific health care organizations, and overseeing performance improvement plans.

Section III

Continuity of Care Considerations

Background

While the ACA will expand health care coverage and make health insurance affordable for millions of Americans, analysts predict that its implementation could exacerbate churning and other types of discontinuous coverage. For the purposes of this chapter, the term “churn” refers to three types of involuntary movements by an individual within the health care system: from a state of being insured to uninsured, from one health plan to another, and from one cost-sharing structure to another within the same plan.³⁶ Consumers who are unsupported through these types of coverage transitions may experience confusion with plan rules, disrupted relationships with providers, and increased deferral of treatment. Mitigating these negative effects is particularly important in Oregon, where it poses a major threat to the effectiveness of the CCM and the Triple Aim.

Though the Medicaid threshold has historically been the critical point for churn, new ACA provisions create additional challenges to maintaining continuity of care. In 2014, the ACA adds a requirement for those who receive Medicaid or subsidies to claim they do not have an affordable ESI offer. This adds ESI premium levels, employer offer rates, and hours worked to the mix of indicators that could impact eligibility in public assistance programs.

The ACA will also add a tiered subsidy program for individuals and families just above the Medicaid threshold, with seven distinct subsidy levels between 133 percent and 400 percent of the federal poverty level (FPL). As income increases, the size of the subsidy decreases, zeroing out when income reaches 400 percent FPL. Overpayments of exchange subsidies, which can be caused by changes in income or living conditions over the course of the year, must be corrected through “reconciliation” payments at the time of annual tax return filing.

Thus, there are four possible types of insurance coverage volatility Oregon should monitor:

- Medicaid participants who become uninsured,
- Beneficiaries who change eligibility between Medicaid and exchange subsidies,
- Exchange subsidy recipients who change eligibility within subsidy tiers, and
- Exchange participants who become eligible for the exchange subsidies.

Key Issues

Disruptions in coverage between the Oregon Health Plan and Qualified Health Plans: Although the Oregon Medicaid Advisory Committee (MAC) chose a benchmark plan for the Medicaid expansion population, Oregon Health Plan Plus (OHP Plus), that would “minimize disruption around coverage and benefits for individuals that transition between the Oregon Health Plan (OHP) and Qualified Health Plans (QHPs),” individuals that transition between Medicaid and the exchange will still experience changes in covered benefits, provider networks, cost sharing, and plan rules.³⁷

One of the most common types of coverage disturbance is among individuals with less than one of year enrollment in OHP.³⁸ Although some of the individuals who disenroll quickly from OHP gain insurance through employers or the individual market, the majority experience a lapse in coverage. Short enrollment

followed by a period of uninsurance shifts costs to safety net providers and risks the clients' health by causing them to forgo preventative care and delay needed care. These negative outcomes may be mitigated if the OHP members were guided through transitions or could opt-in to OHP-like coverage as they experience life changes that affect their eligibility.

Gap in Affordability between OHP and QHPs: The gap between OHP and affordable commercial insurance is wide, such that individuals and families that become ineligible for Medicaid often involuntarily leave the insurance market. According to an internal churn report for the state by the Center for Outcomes Research & Education (CORE), most recent disenrollees from Medicaid are uninsured because “the income level that disqualified someone for OHP is still too low for most people to buy health insurance once they are out of the system.”³⁹ When the ACA is fully implemented in 2014, the gap between Medicaid and individual coverage in the commercial market will widen. A Wakely Consulting Group report for the State of Oregon estimates that individual market premiums will be 24 percent higher than 2011 levels on average, before tax credits are considered.⁴⁰ Although Wakely estimates that overall insurance costs in the individual market will *decrease* by 23 percent on average after taking into account exchange subsidies, recent disenrollees may not perceive the insurance as affordable or may experience income variability that could negate the advantages of tax credits.

Income Variability and Reconciliation Payments: As Table 1 shows, the reconciliation payment amounts are capped by income level, ranging from \$600 for families below 200 percent of the federal poverty line, to \$2,500 for a family between 400 and 500 percent of the poverty line, to a full amount of the advanced subsidy for families above 400 percent of the poverty line.

Table 1: Reconciliation Payment Caps by Income Level

Household Income	Income Limit (Family of Four)	Family Repayment Amount Cap
Less than 200% FPL	\$46,100	\$600
200 – 300% FPL	\$69,150	\$1,500
300 – 400% FPL	\$92,200	\$2,500
More than 400% FPL	Above \$92,200	Full amount of advance payment

Source: Internal Revenue Service. Income limits based 2011 HHS poverty thresholds.⁴¹

The steps between repayment caps for incremental increases in income level are fairly modest. However, life events can result in major jumps, moving from a cap of \$600 to a cap of thousands. Consider the following scenarios:

- *Scenario 1:* A family of four with one worker has an annual income of \$55,000, about 240 percent FPL. The second spouse enters the workforce, raising the family's income to \$93,000, just over 400 percent FPL. Over the course of the year, the family receives \$12,200 in subsidies based on the lower income amount. The family will owe the full \$12,200 back in additional taxes at the end of the year.⁴²
- *Scenario 2:* For the same family as in Scenario 1, the out-of-work spouse enters the workforce but for a slightly lower-paying job, raising the family's income to \$92,000, just under 400 percent FPL. As a result of taking the lower-paying job, this family will owe only \$2,500 in reconciliation payments, saving nearly \$10,000 in taxes.

A Kaiser Family Foundation (KFF) report found that 11 percent of all subsidy-eligible families (those between 138 percent and 400 percent FPL) in 2004 had incomes above 400 percent FPL two years later and would have been liable for the entire reconciliation payment. Should Oregon's experience mirror these national numbers, there will be a large number of Oregon families facing significant reconciliation payments following implementation of the exchange in 2014.

Analysis

Efforts to Preserve Continuity of Care: Lessons from Experience

While continuity of care is both an acute and chronic problem, this report has narrowed its analysis to those solutions that are caused by income volatility and to those that can be implemented in a three- to five-year time frame. The authors recognize that OHA is already working on benefit alignment between OHP and QHP markets that would promote continuity in the type and amount of services provided in the long term. The authors also recognize but do not comment on broader alignment of purchasing strategies and contracting frameworks between OHA and Cover Oregon. This section instead considers a narrow set of federal and state-led efforts to reduce disruptions in care for Medicaid recipients and considers whether they could be successful in Oregon.

Basic Health Program: In states that opt to create a Basic Health Program (BHP), individuals and families with incomes just above the Medicaid eligibility threshold (between 139 and 200 percent FPL) would be covered by health plans that contract with the state.⁴³ These plans would be more comprehensive than typical commercial plans on the exchange, mimicking Medicaid plans' provider networks and managed care delivery system. Funding for the BHP would come from the same federal funds that would have been given in the form of tax credits for that income category, as well as cost-sharing from consumers. The BHP was intended to be a natural link between public and private insurance, reduce churn, and ease rate shock as individuals move from low-cost Medicaid plans to subsidized but sometimes cost-prohibitive plans on the exchange.⁴⁴ However, critics note that the BHP could contribute to the market segmentation introduced by the ACA's multiple income categories and benefit packages, as well as destabilize the risk pools in the nascent exchanges.⁴⁵ Due to these potential issues, as well as the responsibility of states to pay for setup costs and insufficient federal guidance, the BHP has not been a popular coverage solution in Oregon or many other states.

Transition Plans for Continuation of Coverage: Transition planning can help beneficiaries vulnerable to churn adjust to changes in health care coverage and provider networks. A number of states—Maryland, Arizona, Indiana, Massachusetts, Minnesota, New Mexico, New York, and Pennsylvania—already require receiving and relinquishing Medicaid Managed Care Organizations (MMCOs) to share medical records, pay for the continuation of certain treatments, and identify a transition coordinator to manage the conversion. Some states also require MMCOs to cover ongoing treatments for certain vulnerable patient groups that are either leaving or entering their plans for 90-120 days after the transition.⁴⁶

No specific cost estimates are available for including such provisions in insurance carrier contracts. Insurers may benefit in unpredictable ways, depending on the volume and direction of member flows (e.g. when one plan is burdened with covering a complex case, another plan benefits). However, there are clear benefits to OHP members; transition plans would minimize gaps in care, improving health outcomes and reducing unnecessary illness.

Tennessee's Bridge Plan: Tennessee's "one family, one card" idea intends to allow low-income families with eligibility for different public insurance programs to gain coverage under a common plan. The so-called bridge product would be a special silver-level managed care plan on the state's health insurance exchange but would only be available to individuals enrolled in Medicaid in the last six or 12 months or those with a dependent who has been enrolled in Medicaid during that time.

Bridge plans provided by MMCOs would likely have lower premiums than typical silver-level QHPs on the exchange, drawing low-income consumers who are price-sensitive and want to retain their MMCO-provided provider network and level of coverage. Low-income consumers who only consider premium costs when buying health insurance may instead select a bronze-level plan that features a low or zero-dollar premium,

high cost sharing, and lower levels of coverage. Therefore, bridge plan enrollment levels would depend on the ability of eligible consumers to calculate the most cost-effective plan amid often confusing insurance terms. As a series of Consumers Union studies indicate, consumers find it difficult to interpret terms such as *co-insurance*, *out-of-pocket limit*, and *allowed amount* to calculate a plan's overall value.⁴⁷ However, if low-income individuals lack trust in and understanding of health insurance plans, they may opt for less financially risky options regardless of premium cost. As Consumers Union notes, people who are less certain about health insurance plan details strongly prefer “an HMO-style plan with fixed co-pays” because payments are more predictable.

Providers are likely to benefit from a bridge plan because of the balance of payments between the consumer and the state.⁴⁸ As the Tennessee Insurance Exchange Planning Initiative notes in its 2011 Bridge Option proposal, providers may experience lower reimbursement rates, but also a lower risk of bad medical debt as compared to a standard bronze-level plan.

One barrier to the adoption of a bridge plan is the potential to dilute the calculation of premium credits, which are based on the second lowest cost silver plan offered through the exchange. State officials have proposed that the federal government exclude the bridge options from the determination of the benchmark plans since their lower premiums would decrease the value of premium credits for Tennessee residents. Although the final health insurance premium tax credit rule issued in May 2012⁴⁹ excludes plans closed to an individual or family upon enrollment from tax credit calculation, plans that close during the year are still considered. Thus, it is not clear whether the federal regulations would use a bridge plan product in the tax credit calculation.

Another potential barrier to adoption is whether the tax credits can be applied to bridge products. As Tennessee's legal advisors note, former Medicaid enrollees may apply tax credits to Medicaid plans that are recognized as QHPs and authorized by the state to accept a limited enrollment; individuals would not be able to use tax credits for Medicaid plans that are not recognized as QHPs, limiting the ability of those individuals to afford such plans.⁵⁰

Oregon's Medicaid Buy-in Program: Created in the late 1990s, the Medicaid Buy-In (MBI) program was created to remove barriers for disabled individuals on SSI or SSDI and eligible for Medicaid to maximize their independence and earning potential as well as encourage a “culture of coverage”; the law allows them to rejoin the workforce without compromising their access to health care coverage.⁵¹ Specifically, states were granted the ability to extend Medicaid coverage to those disabled individuals with incomes up to 250 percent FPL and to apply sliding-scale premiums and cost sharing based on income. The MBI program has succeeded in improving the employment and health care of recipients and has gradually gained national popularity.

Oregon was an early implementer of the MBI program: the Employed Persons with Disabilities (EPD) program was created through a Medicaid State Plan amendment and implemented in 1999. Individuals who meet the Social Security Administration definition of disability and have taxable income are eligible to enroll.^{52,53} Over 1500 individuals (0.01% of SSDI disabled workers) currently participate in the EPD program and pay between \$0 and \$150 in monthly premiums.⁵⁴

Refundable Tax Credits: Lessons from Experience

While historical income variability can shine some light on the extent of overpayments and underpayments, historical income data alone is not enough to tell us how Oregonians will interact with the Advance Premium Tax Credit (APTC). Experience administering previous tax credits in the U.S. and elsewhere can both help us predict how Oregonians will interact with the new benefit and help the state prepare for a more effective implementation that minimizes mispayments and maximizes continuity of care. This section reviews several such refundable credits, compares the similarities and differences with the APTC, and reflects on relevant lessons learned.

The Advance Earned Income Tax Credit (AEITC): The largest U.S. refundable tax credit is the Earned Income Tax Credit (EITC), which in 2011 amounted to about \$60 billion. Similar to the APTC, the EITC slowly phases out in size as income increases.⁵⁵ For the purposes of the comparison, a small subset of the EITC is particularly instructive—the Advance EITC (AEITC). While the EITC is paid as a tax refund upon tax filing, the AEITC allowed EITC recipients to receive their benefit based on expected income for the year.

AEITC: Key Similarities to APTC	AEITC: Key Differences with APTC
<ul style="list-style-type: none"> • Paid out on a monthly basis • Monthly amount based on predicted income for the upcoming year • Overpayments must be reconciled • Underpayments are correct • Similar target population by income⁵⁶ 	<ul style="list-style-type: none"> • Monthly payments capped at 60% of the value maximum end-of-year EITC, whereas full amount of APTC can be claimed⁵⁷ • Reconciliation payments <i>not</i> capped by income—overpayments had to be repaid in full at time of tax return filing • Payments funneled through an employer to the employee rather than directly to the provider

Lessons learned from the AEITC:

- *AEITC was an unpopular alternative to EITC.* An analysis by the Government Accountability Office (GAO) of the AEITC found that only 3 percent of eligible AEITC recipients chose the monthly payments over the annual EITC. Of those who did opt for AEITC, about half received less than \$100 over the course of the year. Despite several targeted efforts by the IRS, including outreach to specific groups, AEITC use has not increased.⁵⁸
- *Workers prefer annual EITC payments to monthly payments.* The GAO report concluded: “IRS officials, other experts, and our prior work suggest that individuals often do not elect the AEITC because they prefer receiving the entire EITC as a lump sum when filing their tax return.”⁵⁹ A recent study by Harvard sociologist Sara Greene corroborated these findings in interviews with a 194 EITC recipients who “overwhelmingly” reported a preference “to receive the EITC as a lump sum” rather than in monthly payments.⁶⁰
- *AEITC-eligible workers feared mandatory reconciliation payments.* An IRS-funded study found that AEITC-eligible workers were concerned that they “would receive more in advance than they would ultimately be entitled to, thus owing the difference when filing their tax return.”⁶¹ Similarly the EITC recipients Greene interviewed were “afraid that if they took an advance on the [EITC], they would ultimately owe the IRS money at the end of the year.”⁶²
- *AEITC error rates were very high.* Roughly 80 percent of AEITC recipients did not comply with at least one the credits requirements. For example, only 60 percent of recipients filed their annual tax return, as required. Of those that did file, two-thirds misreported the amount of AEITC that they received. The vast majority of this misreporting (more than 90 percent) was due to *non*-reporting of AEITC amounts, not under- or over-reporting.⁶³

The Health Insurance Tax Credit (HITC): The first refundable tax credit to subsidize health insurance was the Health Insurance Tax Credit (HITC), passed in 1990 by Congress and repealed three years later.⁶⁴ HITC piggybacked on the EITC to offset the cost of premiums for low-income workers who bought health insurance that included coverage for their children. The average credit covered 20-25 percent of health insurance premiums for recipients, but the credit was poorly advertised and is estimated to have only increased coverage among the target population by 6 percent.^{65,66} Only about 25 percent of those eligible took advantage of the credit, compared with more than 80 percent of those eligible for EITC at the time.⁶⁷

HITC: Key Similarities to APTC	HITC: Key Differences with APTC
<ul style="list-style-type: none"> • Directly subsidized purchase of health care through refundable credit • Targeted similar population (same as EITC) 	<ul style="list-style-type: none"> • Paid on an annual basis, unlike APTC • Paid directly to the individual rather than to the provider, unlike APTC • Paid as a reimbursement for purchase rather than as a subsidy at time of purchase • Covered a much smaller percentage of premium costs

Lessons learned from the HITC:

- *Lack of adequate outreach harmed take-up rates of HITC.* Reviewing the lessons from HITC, the Kaiser Family Foundation concluded that “the eligible recipients will need to be educated regarding the program and, second, the tax credit/subsidy will have to be relatively high compared to the out-of-pocket costs borne by the target population.”⁶⁸ The APTC is much more generous than HITC, but without a strong outreach plan, participation rates may fail to reach desired levels.

The Health Care Tax Credit (HCTC): Nearly a decade after the repeal of HITC, Congress created the Health Care Tax Credit (HCTC) to cover 65 percent of premium costs of trade-displaced workers. From 2002 until passage of the ACA, the HCTC was the only tax credit in existence used to subsidize health coverage for potentially uninsured adults.⁶⁹ APTC’s structure closely resembles HCTC’s, which was at the time a “revolutionary” monthly refundable taxpayer’s credit provided directly to the insurance carrier (rather than the taxpayer), with reconciliation payments made annually at the time of tax return filing.⁷⁰

HCTC: Key Similarities to APTC	HCTC: Key Differences with APTC
<ul style="list-style-type: none"> • Monthly payments made to qualified health plans for a percentage of premium costs • Alternative end of year refundable credit instead of monthly premium payments • Underpayment of benefits can be reconciled during end of year tax filing • Similar population targeted—uninsured, low-income workers 	<ul style="list-style-type: none"> • No possibility of overpayment, so no reconciliation payments by the recipient • HCTC amount dependent only on cost of premium, not beneficiary’s income • Covered a much smaller percentage of premium costs for low-income workers below about 250 percent FPL⁷¹ • Individual pays HCTC program, which then pays provider

Lessons learned:

- *Complex enrollment processes and high upfront costs deter participation.* HCTC participants were required to complete application forms with three to five different agencies in order to enroll in the program, depressing take up.⁷² Years after implementation, take-up the credit was between 13 percent and 21 percent of eligible taxpayers.⁷³
- *A large minority of HCTC opted for end of year payments rather than monthly payments.* Unlike the AEITC, monthly HCTC did not face the threat of future reconciliation payments. Still, the portion of HCTC participants who opted for the annual HCTC benefit instead of the monthly HCTC benefit ranges between 23 percent and 51 percent.⁷⁴

Recommendations

Recommendation III.1: Require transition plans to ease changes in coverage.

Cover Oregon and OHA could add transition plan clauses that include mechanisms, such as continuation of certain medical treatments or the prompt exchange of medical records, to contracts with insurance carriers

and CCOs. Oregon could model coverage transition plans off of those in New Mexico and Minnesota to extend the continuity of care of individuals who cannot avoid crossing back and forth between QHPs and OHP. At the very least, CCOs and QHPs should be required to coordinate care for medically needy individuals (those who are pregnant or have chronic and complex diseases). Since carrier certification occurs once every two years, this recommendation would apply to Cover Oregon's 2015 RFA (for benefits provided in 2016 and 2017).

There are several benefits to this approach. It saves administrative costs by reducing volume of churn, improves continuity of care for individuals with frequent changes in eligibility, clarifies point of accountability during coverage transitions, and manages care for patients with complex needs and unstable income. Since Oregon has already made great strides in setting up the CCM within provider networks, encouraging the coordination of patient care across plans would be a logical next step.

CCOs would likely bear much of the cost of transition plans. However, their PCPCH model should allow them to easily provide receiving insurers the necessary care plans for vulnerable populations. Contract language could also be altered to place the burden of transition plans on the receiving plan, so that QHPs and CCOs would share these costs.

Recommendation III.2: Implement the bridge program or expand the Medicaid Buy-In program to close gaps between OHP and QHPs.

Alignment between OHP and the exchange is complex, but would fit Oregon's style of comprehensive and direct health reform solutions. Integration of OHP and the exchange could also serve as a BHP substitute without additional market segmentation. HHS released FAQs⁷⁵ on December 10 that allows an issuer with a state MMCO contract to offer a QHP as a Medicaid Bridge Plan if it limits enrollment to certain populations (such as those previously eligible for OHP) and if its provider network has sufficient capacity for these enrollees. The state must have a contract with CCOs that requires them to provide coverage to eligible bridge individuals and includes "provisions to prevent cost-shifting from the non-Medicaid/CHIP population to the Medicaid/CHIP population." This recommendation could apply to Cover Oregon's 2015 RFA or be implemented as a mid-cycle amendment, depending on reception by CCOs.

For such an alignment to work, the CCO must meet the QHP certification requirements. While OHA's current CCO standards are robust, they do not completely align with the exchange standards. First, CCOs are not licensed by the Oregon Insurance Department. The capacity of CCOs to offer plan levels of different actuarial value and pay fees and commissions is questionable. However, it is possible that the National Committee for Quality Assurance (NCQA) could derive an accreditation that would fit a CCO's bridge plan. It is also likely that CCOs would be able to meet the QHP standards (if added to their contracts) for enrollment management, cost-sharing reductions, and risk adjustment. Table 2, below, illustrates the overlaps, gaps, and potential alignment opportunities between current CCO and QHP standards.

If Oregon can assist CCOs in obtaining QHP certification, the bridge program could offer more comprehensive and consumer-friendly health coverage to individuals whose volatile eligibility status would have caused unwelcome transitions between OHP and the exchange. However, the bridge plan may reduce the value of the tax credit if federal officials do not clarify the tax credit calculation regulations.

A second-best solution would be an expansion of Oregon's current MBI program. CCOs would not need QHP certification to allow buy-ins, but OHA would need to make changes to the MBI program to limit fiscal exposure to the state and position it as a public health initiative. For example, OHA should:

- Expand the eligible population to non-disabled adults previously enrolled in Medicaid during the last 6-12 months,

- Charge a higher range of premiums though the income-based sliding scale, and
- Change the policy framing from a work incentive to a preventative health care incentive.

Table 2: Comparison of CCO and QHP Standards

Requirements for QHP Issuers	Full CCO Compliance
Solvency	✓
Network Adequacy	✓
Plan Offerings	
Each QHP must offer EHB	✓
Offer a child-only plan in the same tiers	✓
Quality improvement & reporting	
Effective case management & care coordination	✓
Lower hospital readmissions & medical errors	✓
Wellness & health promotion activities	✓
Marketing	✓
Requirements for QHP Issuers	Partial CCO Compliance
Accreditation	Alternative NCQA accreditation possible (ACO, Care Management)
Enrollment Management	No explicit CCO requirement, but has capacity to meet QHP standards
Cost-Sharing Reductions	No explicit CCO requirement, but has capacity to meet QHP standards
Risk Adjustment	No explicit CCO requirement, but has capacity to meet QHP standards
Requirements for QHP Issuers	Gap in CCO Standards
Licensure	Though some of the participants of CCOs are licensed insurers, the CCOs themselves are not
Plan Offerings	
Offer a plan in the silver and gold tiers	Capacity of CCOs to offer different AV plan levels is questionable
Exchange Agent management	Capacity of CCOs to pay commissions to brokers is questionable
Fees & Assessments	Capacity of CCOs to pay assessments is questionable

Recommendation III.3: Employ established principles of behavioral psychology to guide decision-making on Cover Oregon.

The exchange presents individuals with a series of complicated decisions about coverage and subsidy allocation. For Oregonians most likely to churn, the stakes are high. Oregon may consider strategic presentation of information as a mechanism to promote certain decisions that will mitigate the negative effects of churn and income variability.

Given the complexity and widespread dearth of knowledge inherent to insurance purchasing, people are extremely susceptible to cognitive biases and flawed decision-making. Behavioral research tells us that in situations in which choice is time-consuming or challenging, choice architecture can be powerful.⁷⁶ The state can leverage established principles of behavioral economics, including defaults and loss aversion, in three key ways to increase continuity of care:

1. Emphasize the importance of accurate and updated income disclosure upon sign-up and over time;
2. Nudge individuals to take smaller percentages of their subsidies each month, so as to encourage savings and buffer against large reconciliation payments; and
3. Encourage Oregonians to opt for plans that offer continuity of provider availability across Medicaid and commercial products.⁷⁷

Leveraging Defaults

Defaults are powerful instruments for influencing client behavior. The framing of a choice – whether between flavors of ice cream or health care plans – can significantly impact outcomes. Human inertia favors the default as a quick choice that does not require additional cognitive burden. Additionally, a default option is often seen as an authoritative recommendation from an assumed expert.⁷⁸ Research conducted by the Pacific Business Group on Health and CalPERS shows that consumers accept the default display of health plan information without customization 93 percent of the time.⁷⁹

Reducing reconciliation payments through APTC choices: Experience with the AEITC shows that advance payments for low-income populations are prone to high error rates. The state can reduce the incidence and size of reconciliation payments by nudging individuals to take smaller percentages of their subsidies in advance. To reduce the frequency and magnitude of reconciliation payments in case of income change, the state may encourage individuals to wait until the end of the year to collect their tax credits. Experience with both the AEITC and the HITC indicates that a sizable portion – perhaps even a majority – of subsidy eligible exchange participants would in fact *prefer* this option. Defaults are powerful tools to encourage desired choices. For example, after the user is informed of the amount of tax credit, as well as a list of pros and cons of a monthly versus an annual credit, he/she may be presented with a version of the following screen:

Adjust the slider or enter an amount to set your \$1,500 tax credit.

If your actual household income for 2014 is more than you expected, you may have to repay some or all of the monthly tax credit. You will be able to adjust this PTC setting again when you choose your health plan.

Reminder: By choosing to claim your tax credit at years end, there is no risk of having to repay

Monthly Tax Credit

\$0

Annual Tax Credit

\$1,500

Confirm

Figure 1: Leveraging Defaults (based on ux2014.org prototype)

The “pre-set” monthly tax credit is presented at zero, but can be easily moved by the user. Additionally, a pop-up box appears, confirming that under the current selection, the user is not at risk of reconciliation payments when filing taxes.

Encouraging continuity through choice of plan: Cover Oregon may similarly consider strategic use of defaults in its presentation of health plans to clients. Specifically, it could nudge people – especially those whose income nears the Medicaid-subsidy threshold – towards plans that offer continuity of provider availability.

Framing Loss Aversion

People are strongly loss-averse. As the research of Nobel-Prize-winning behavioral economist Daniel Kahneman finds, a loss of \$10 is more aversive than a gain of \$10 is attractive.⁸⁰ Thus, by framing a choice as a potential loss, individuals are much more likely to make a decision that avoids that loss. A 2012 Harvard and University of Chicago study demonstrated the power of loss aversion in improving teacher quality. Teachers were paid financial incentives in advance but asked to give the money back if their students did not demonstrate sufficient academic improvement. In these classrooms, student math scores improved by a margin equivalent to one standard deviation of teacher quality, as compared to a control group of traditionally incentivized teachers.⁸¹ Oregon can similarly exploit loss aversion to encourage desirable choices.

Reducing reconciliation payments through APTC choices: This intuition may be applied to the presentation of choices on the exchange. When determining the size of a tax credit, for example, the user may be presented with a pop-up box that makes clear the potential reconciliation payment (“loss”), in the event of income change. For example see Figure 2 below:

Adjust the slider or enter an amount to set your \$1,500 tax credit.

If your actual household income for 2014 is more than you expected, you may have to repay some or all of the monthly tax credit. You will be able to adjust this PTC setting again when you choose your health plan.

Monthly Tax Credit

\$50

Annual Tax Credit

\$900

Confirm

Note: If your income changes over the next year, you may need to pay back as much as: \$600

Figure 2: Framing Loss Aversion (based on ux2014.org prototype)

Encouraging continuity through choice of plan: Loss aversion can also be a helpful approach to encourage participation in APTC. As experience with the AEITC, HITC, and HCTC showed, effective outreach is key to uptake. HITC is particularly instructive. In high numbers, HITC participants opted for insufficient coverage because the insurers provided a simple sign-up process that was fully paid for by the credit. Insurers presented the plans as a free benefit that low-income workers were losing by not signing up. While this practice was contemptible given the quality of coverage, it was successful. The exchange subsidies are far more generous than the HITC. Thus, Cover Oregon has the opportunity to present quality coverage in the same way in order to increase take-up rates among low-income populations.

Encouraging accurate and updated income disclosure upon sign-up and over time: The same intuition may be applied to encourage users to accurately report and regularly update income information. Data and other

resources that identify worker income, such as the work number, quarterly wage statement, and unemployment insurance data, are not uniformly available and are often out-of-date. Thus, incorrectly-reported income or unreported changes in income can go unnoticed for months, leading to costly reconciliation payments and discontinuity of coverage. As before, the exchange should highlight these potential losses for users in order to encourage accurate and timely reporting. See Figure 3 below:

Total Household Income for 2014		\$25,769.00
Your Household Income Summary for 2014		
Job Income	+ \$24,986.00	<input type="button" value="Edit"/>
Self-Employment Income	+ \$0.00	<input type="button" value="Edit"/>
Other Income	+ \$783.00	<input type="button" value="Edit"/>
Adjustments	- \$0.00	<input type="button" value="Edit"/>
Total Household Income for 2014	\$25,769.00	
<div style="border: 1px solid red; padding: 2px;">Please confirm that the income listed is accurate. Listing an incorrect income may put you at risk of significant payments when you file taxes</div>		<input type="button" value="Next"/>

Figure 3: Loss Aversion and Reporting (based on ux2014.org prototype)

Section IV

Behavioral Health and Physical Health Integration

Background

Oregon's CCM aims to achieve the Triple Aim: better outcomes and improved quality of care at lower costs. It will do so by emphasizing key elements: alternative payment models, patient centered primary care homes (PCPCH), integration of behavioral, physical, and oral health, quality measures for accountability, and alignment with community health goals.⁸² This model will begin the Medicaid population and later extend to state employees and educators, eventually affecting one in four Oregonians. Using the state's large and increasing purchasing power, the ultimate goal is that this model will bring enough citizens, providers, and commercial plans into the fold to simultaneously change how health care in Oregon is delivered, while achieving the Triple Aim.

Defining Behavioral Health and Physical Health Integration

Definition of Behavioral Health

Behavioral health disorders are frequently associated with health issues related to a person's mental wellbeing. Problems related to behavioral health are associated with mental disorders and fall within two categories: (1) Mental illness: Mood disorders (i.e. depression, bipolar disorder), anxiety disorder, schizophrenia, and attention deficit hyperactivity disorder (ADHD) and, (2) Substance abuse: Alcoholism and drug abuse.

Defining a Behavioral Health Worker

A behavioral health worker (also referred here as a behaviorist) is a highly trained behavioral health expert working in the mental health and substance abuse fields. A behaviorist can include: board certified psychiatrists, licensed professional counselors, licensed clinical social workers and registered nurses.

Behavioral Health and Physical Health as a Continuum: Collaborative and Integrated Care

Behavioral health and physical health (BPHH) care models are widely considered fall on a spectrum and have varying levels of care. The phrases coordinated care, collaborative care, and integrated care are often used inconsistently, which is why we aim to clarify our intentions in this report. Here we define *coordinated care* as health care providers working separately and exchanging information when necessary. In a *collaborative care* setting, patients receive separate services from a behaviorist who then closely collaborates with the patient's primary care provider. In contrast, *integrated care* involves a behavioral health provider working in the primary care setting as part of the primary care team. Although there is a range of integration models, each one involves a behaviorist who is a part of a primary care team, which provides routine behavioral care as an extension of PCPCH service. Co-location (where the behavioral care provider and the primary care provider are in the same location) can occur for both collaborative care and integrated care; the general distinction is that integration includes co-location and its full inclusion in the PCPCH setting.

One of the major pillars within the CCM is the effective integration of behavioral health and physical health (BPHH). While the behavioral health care delivery system has drastically altered over the last few decades and transitioned from mainly inpatient treatment to community-based outpatient care, it remains largely separated from physical health care. The demand for behavioral health care, specifically for mental disorders, remains high and will likely continue to rise. Nearly half of Americans can expect to have a mental disorder in their

lifetime and in 2011, eight percent of Americans (12 years or older) were classified as being dependent on at least one substance.^{83,84} Within the United States, one in four Americans experience a mental health disorder each year, with less than one-third of identified adults receiving care.⁸⁵ Low-income earners tend to have poorer mental health status than middle or high-income earners.⁸⁶ Racial and ethnic minorities tend to have less access to mental health care and once they receive these services, they tend to have poorer quality care, thus becoming a factor in health disparities.⁸⁷ Furthermore, many people with behavioral health disorders face an increased risk of comorbidity and are likely to die 25 years earlier, often due to preventable and treatable diseases.⁸⁸ Mental health disorders, specifically depression and anxiety, are expected to rise globally, such that depression is already the leading cause of illness within the Western world and is projected to increase.⁸⁹ Subsequently, the CCO model looks to overhaul the traditional siloed delivery system that has resulted in poor quality care and coordination and high costs and create a system that will eventually become fully integrated.

Beginning the CCM with the Medicaid population has great potential to reduce health care costs, particularly through effective integration of behavioral and physical health. Medicaid is the leading payer of mental health services in the nation, paying 27 percent of all expenditures for mental health services.⁹⁰ In 2008, 11 percent of Medicaid recipients identified with mental health disorders in the United States accounted for nearly 30 percent of all Medicaid expenditures.⁹¹ Current Medicaid recipients with behavioral health disorders also have higher rates of comorbidities and use a disproportionate number of health services relative to Medicaid recipients without behavioral health disorders.⁹² Furthermore, many of those currently uninsured who are expected to benefit from the Medicaid expansion through the ACA have various unaddressed health issues, including behavioral health.⁹³ As they enroll into Medicaid, experts expect this group to seek care for issues they previously could not address at higher rates than those already on Medicaid. As the Medicaid population already has high expenditures, successfully confronting BHPH integration in the primary care setting through routine screening, early intervention, and consistent managed care would result in increased access by Medicaid recipients and all who use Oregon's CCOs. This would ultimately lead to better outcomes for patients, reduced health disparities by class and race/ethnicity, and also produce large savings for the state of Oregon.

Key Issues

Transformation Plan: The OHA has required that each of the 15 CCOs must write a transformation plan, comprised of eight sections, and is intended to be an individually tailored strategy, identifying specified targets and deliverables that will assist CCOs in becoming a fully cohesive organization best serving their communities. The transformation plan is essentially having each CCO do a thorough inventory of their health care system and requiring a timeline of quality improvement measures and benchmarks. Since the transformation plans will enter CCO contracts as an amendment, they will also increase transparency during this transformation process and likewise serve as an accountability mechanism. Additionally, this plan will further facilitate the CCO-OHA partnership as each CCO will have a primary contact (the innovator agent) within OHA to whom they will refer their questions. The innovator agent will then have the option to confer with a subject matter expert (SME), who is to be an expert on one of the eight subtopics of the transformation plan.

One of the eight elements of the transformation plan is BHPH integration. This section identifies seven areas to promote thorough BHPH integration.

1. Prevention, promotion, early identification and early intervention
2. Shared health information
3. Training and cross training
4. Individuals with serious and persistent mental illness
5. System of care

6. Transitions of care
7. Recovery management⁹⁴

In addition to providing a template of BHPH transformation, the OHA has also provided CCOs with sources already identified as best practices to assist them with BHPH integration. Some resources for CCOs are: 1) The four quadrant model, an evidence-based method used to assist providers in deciding whether patients should be treated in the primary care and/or the behavioral care setting; 2) Screening, brief intervention, and referral to treatment (SBIRT), an evidence-based method to assess and intervene in alcohol and drug abuse used in the primary setting; and, 3) Early assessment and support alliance (EASA), a support system for children and adolescents who are experiencing psychosis with the ultimate goal to reduce long-term disability associated from psychosis.⁹⁵

Transformation Center: The Center for Health System Transformation (Transformation Center) is still in the process of formation, though its purpose is quite clear. It is to operate as the central point for health system innovation and facilitate and enhance the CCO model. The Transformation Center will work directly with CCOs through innovator agents, who are to be the primary contact between CCOs and the OHA. The Transformation Center will work to increase the rate of sharing best practices, establish learning collaboratives, offer technical assistance, so that CCOs are best able to quickly deliver the highest quality service using evidence-based practices, while decreasing health care costs.

Funding for Co-location: Although CCOs will begin the BHPH integration process from varying starting points, the ultimate goal is for all CCOs to have full BHPH integration in the PCPCH. This may prove difficult in the short term as many primary care clinics are experiencing funding shortfalls, limiting their abilities to fund a full time behaviorist in the PCPCH. Though a behaviorist in the primary care setting is widely viewed as the most cost effective approach, funding remains a major obstacle in the short term for some primary care clinics.

Expanding the BHPH integrated model: Since CCOs were not designed to be exclusively for Oregon's Medicaid population, the current structure for CCOs with a behaviorist co-located and integrated in the PCPCH is leading to inconsistent care for patients. Those on Medicaid are able to have standard care for that particular clinic, which includes a behaviorist when necessary. Patients not on Medicaid, however, may not be able to have access to the behaviorist if their health insurance plan does not cover a behaviorist consultation during a visit at a primary care clinic. Thus a provider must consider a patient's health insurer when providing care and is not able to offer the equal care to his or her patients. Furthermore, negotiating with commercial health insurance plans to cover a behaviorist in the PCPCH may prove to be difficult as currently all commercial plans have mental health carve outs, which is a health system incongruent with what the CCO provides. This is an area that must be thoroughly analyzed so that clinics with mainly Medicaid patients and those with a combination do not have diverging outcomes caused solely by an inability to consistently provide care to patients.

Analysis

BHPH Integration: Considering Case Studies

The following case studies were chosen as examples for how CCOs could integrate BHPH care into their delivery services based on different starting points and targeting different populations.

Tennessee: Cherokee Health Systems: Cherokee Health Systems in eastern Tennessee serves the Medicaid population, receiving a capitated rate, and has fully integrated physical and behavioral health in 12 of 22 of its clinics. Cherokee Health Systems started as a community mental health care center and then integrated primary care to become a Federally Qualified Health Center (FQHC).⁹⁶

In integrating behavioral and physical health, Cherokee Health Systems follows a “behaviorist” model: they embed a behavioral health worker in their primary care clinics to conduct quick behavioral screenings and treatment as part of a patient’s primary care visits. The behaviorist uses SBIRT and when needed, each clinic has a psychiatrist, usually off-site, who receives referrals. Electronic medical records facilitate information sharing for every patient. All providers, both for physical health and mental health, can access the entire record. Cherokee Health Systems also uses peer specialists who are lay people from the community who have experience dealing with a family member’s chronic mental illness. These peer specialists are trained and certified by the Tennessee Department of Mental Health and Developmental Disabilities and help patients navigate the health care system. Tennessee has reformed their billing procedures so that primary care providers can bill for the different components of SBIRT, and providers can also bill for telephone consultations. Tennessee also allows billing for peer specialists.⁹⁷

The Cherokee model is widely recognized as being effective. An evaluation of their model found that patient health outcomes improved, patient compliance with treatment increased, both patient and provider satisfaction increased, and the use of expensive specialty mental health services decreased.⁹⁸ After a behaviorist was introduced in the clinic, Cherokee Health Systems experienced a 28 percent decrease in the use of medical services by Medicaid patients, 20 percent decrease for commercially-insured patients, a 27 percent decrease in psychiatry visits, a 34 percent decrease in psychotherapy sessions, and a 48 percent decrease in crisis mobile crisis team encounters. Eighty percent of mental health issues were addressed in primary care without needing a referral to specialty services.⁹⁹

Veterans Affairs: The Department of Veterans Affairs (VA) is one of the pioneers of BHPH integration in the US. They began in the 1990s by piloting two approaches to integration: a behaviorist model and a care management model. Over the past six years, the VA has been moving toward a “blended” model of the two approaches.

In the behaviorist model, the mental health worker is embedded in the primary care clinic. The primary care provider screens for any mental illness, and the mental health provider, usually a psychologist, will immediately follow the primary care provider if needed.

In the care management model, a care manager who is a trained mental health worker, usually a registered nurse, follows up with the patient by telephone after the primary care visit, conducts any additional mental health evaluation and helps the patient adhere to treatment. The care manager coordinates the patient’s care, serving as a liaison between the patient and the primary care provider and referring the patient back to the primary care provider if further care is needed. The care manager is supervised by a psychiatrist.

By blending the two models, the VA is aiming to incorporate each model’s strengths: having a mental health provider on hand to see the patient immediately and having follow up capacity through a care manager for treatment and medication adherence.¹⁰⁰

For information sharing, the VA uses electronic medical records. Tele-consulting is also very important both for treating patients and for communicating information among providers. The VA tested tele-psychiatry with 35,000 in 2009; patients like it because they do not have to commute long distances.¹⁰¹ An evaluation that randomly assigned patients with serious mental illness to integrated care found that they were more likely to use preventative and primary care and had improved physical health outcomes compared to the control group who experienced a decline. Changes in mental health outcomes were not significant perhaps due to small sample size.¹⁰² The care management model could provide a possible middle step for some CCOs as they transition to a fully integrated model.

Table 3: Case Studies by Model Type, Information Sharing and Payment Method

Case Study	Type of Model	Information Sharing	Payment Reform
Tennessee Cherokee Systems	Behaviorist integrated into primary care. Patient follow up by lay peer specialists.	Electronic medical records	Billing reform to allow for SBIRT and teleconsulting
Veterans Affairs	Behaviorist embedded in primary care or a care manager for patient follow up by telephone. Blended approach is being rolled out.	Electronic medical records and telecommunication among providers	N/A: The VA has a unique payment system from its status as its own government agency.
Southeast Pennsylvania Pilot	Navigator in behavioral health clinic who coordinates physical and behavioral care.	Navigator coordination among providers and a common patient profile. Facilitated by guidelines from the state.	Financial incentives to encourage integration
Southwest Pennsylvania Pilot	Care managers at both primary care clinics and behavioral health clinics to coordinate care and follow up with patients.	An integrated care plan and care managers who can convene review meetings among providers. Facilitated by guidelines from the state.	Financial incentives to encourage integration

Southeast and Southwest Pilots of Pennsylvania: In 2009, Pennsylvania launched two different pilot projects designed to better serve co-morbid Medicaid populations with serious mental illnesses. To promote collaboration between behavioral and physical health providers, Pennsylvania established a joint financial incentive program where if certain performance measures were met, both providers would benefit financially from the success. To facilitate information sharing, Pennsylvania issued guidance on consent requirements for sharing certain information among providers. In both projects, it took time and resources to build relationships among providers. The two projects were coordinated by the county and took different approaches since Pennsylvania wanted to give different regions the flexibility to tailor their pilot to the regional situation.¹⁰³ An evaluation on the Southwest pilot by Mathematica compared a group receiving integrated care to a control group found that mental health hospitalizations for the treatment group decreased by 4 percent whereas the control group hospitalizations increased by 10 percent, resulting in a difference of 12 percent. Emergency department (ED) use increased for both groups; the treatment group ED visits increased very slightly, by only three percent, compared to 17 percent for the control group.¹⁰⁴

The Southeast pilot decided that behavioral health homes would serve as the medical homes since that is where the target population generally had the most contact. Navigators were placed in the behavioral health

organization to coordinate patient care. The navigators were similar to the care managers under the Veterans Affairs although, they could also be a nurse, a behavioral health clinician, or a case manager employed by the behavioral health agency.¹⁰⁵ The navigator would communicate with other providers and the patient, develop a care plan for each patient, and ensure information about hospitalizations and emergency room visits was shared. For further information sharing, there is a patient profile that all providers can access that is updated monthly.

The Southwest pilot focused on BHPH with a managed care organization and a behavioral health organization that were owned by the same company but that operated very separately. Company staff working separately in physical and behavioral health at the corporate level were retrained to work more closely with each other, building relationships between staff and learning each other's terminology and practices. At the patient level, care managers from both organizations were used to better coordinate care. These managers already existed but they were further utilized to promote BHPH integration. The care managers conducted most of their follow up work with patients by telephone. They were responsible for developing an integrated care plan and linking patients to services. For complex cases, they convened review meetings that met at least biweekly with both behavioral and physical health providers to discuss patient care. They also helped track hospitalizations and ED visits.¹⁰⁶

Recommendations

Recommendation IV.1: Maximize CCO support function of the Transformation Center.

Dedicate personnel to follow BHPH integration: The issue of integration is complex, and CCOs will rely on the Transformation Center for support. The Transformation Center needs a staff member or consultant focused specifically on BHPH integration to coordinate with experts, innovator agents, and the OHA. The Council of Clinical Innovators could also have an innovator who specializes in BHPH integration.

Establish a clear process for identifying best practices and metrics: As the Transformation Center is being designed a clear process should be determined for evaluating CCO BHPH integration models with the intent of identifying best practices. As part of this process, the Transformation Center should identify metrics that seem to best capture integration and collect any additional metrics in use by the CCOs. Effective measures of integration will eventually be necessary in expanding BHPH integration to other public plans and private plans. In identifying best practices, Oregon can draw on its experience as a leader in using evidence to issue guidance and regulations on the most effective care. Oregon could explore applying elements of the HERC evidence-based review process to evaluating integration initiatives. However, the same level of evidence available for clinical procedures will not be available for evaluating BHPH integration designs, making detailed criteria for identifying best practices even more important. It is essential to identify what entity will be in charge of determining best practices. An impartial body within the Transformation Center, perhaps the Council of Clinical Innovators, could be in charge of reviewing final evidence and recommendations for best practices and giving their approval.

Create a central database of online resources: There are many toolkits and resources available about BHPH integration that could be useful for CCOs. The Transformation Center could create an online portal with the best resources available.

Recommendation IV.2: Encourage information sharing and initial steps for BHPH integration.

Continue to promote the uptake of electronic medical records: Electronic medical records are the most efficient way to ensure mental health and physical health providers can coordinate patient care. Cherokee Health and the Veterans Affairs both rely on electronic medical records and identify them as essential to their

success. OHA could consider mandating that CCOs have electronic medical records in place for their patients.

Encourage initial interaction among different providers: One major challenge to BHPH integration is that behavioral and physical health providers are not used to collaborating in the current health care delivery environment. OHA should encourage CCOs to make initial investments in bringing providers together to meet each other to encourage later information sharing. Both pilots in Pennsylvania found that efforts to encourage interaction were very important to successful integration.

Explore the use of lay specialists in promoting patient care and follow up: CCOs should explore the use of lay specialists in the primary care setting to help patients navigate their behavioral and physical health care. Patients will likely be accustomed to a bifurcated system and they may need to transition to the integrated system. Lay specialists can help ensure patients receive fully integrated care and follow up with patients to ensure they are adhering to treatment, going to appointments, and having their questions answered. Cherokee Health Systems uses peer specialists trained by the Tennessee Department of Mental Health to guide patients. These peer specialists work with the providers in the primary clinic, and their follow-up role is essential to Cherokee Health Systems' success.

In all the case studies considered, staff were available for patient assistance, although the staff were not necessarily lay specialists. While Cherokee Health Systems used peer specialists, other case studies used care managers, nurses, or other navigators to promote continued care and patient follow up.

Identify intermediary steps on the path to full-integrated care: CCOs may not directly transition to full integration since they have the choice to decide their eventual level of coordinated and integrated care. However, the research clearly identifies full-integrated care as being the most effective way for OHA to fulfill the Triple Aim. CCOs will look for guidance on how to begin to implement integration, but OHA should make it clear that full integrated care is the considered the most effective model for BHPH health care. For some CCOs, it might be easiest initially to move into a care manager model that tasks an employee at either the primary care clinic or the behavioral clinic to follow up with patients and begin to coordinate care as in the VA care manager model or with navigators in the Southeast Pennsylvania pilot. Though each CCO will integrate at different paces, they should ultimately strive to have a behaviorist among the primary care team.

OHA will want to organize frequent meetings and learning collaboratives in the first year that bring CCOs together to discuss how they are implementing their BHPH integration plans, what problems they face, and what solutions they have identified. CCOs can learn from each other about how to move along the steps toward integration.

Recommendation IV.3: Address payment and cost issues to facilitate BHPH Integration.

Reform the payment process to incentivize successful BHPH integration. Billing codes need to be revised in order to incentivize providers to integrate their behavioral and physical health services. Providers need to be able to bill for services that are key to integration such as tele-consulting or SBIRT interventions. In the case studies, tele-consulting, either among providers to share information or with patients to treat and provide follow up care, was very important to effective BHPH integration. To encourage primary care as a point of entry for both physical and behavioral health, providers need to be able to bill for the different components of SBIRT interventions.

Explore strategies for reducing costs to hiring behaviorists in the primary care setting.

- 1) **Form a Public-Private Partnership** – OHA could identify a self-insured organization or commercial insurer that would partially fund behaviorists in a CCO primary care setting attended by both Medicaid recipients and the organization's or insurer's employees. The state could

conduct a demonstration to show the cost effectiveness of having full-time behaviorists in the primary care setting. Doing so will allow the state to make use of its purchasing power and make consistent care in the primary care setting much more feasible. If successful, it will also assist in spreading the integration model to all Oregonians and no longer restricting it those on Medicaid.

- 2) **Form a Public-Public Partnership** – Consider a partnership with Medicaid, PEBB, and OEBC; PEBB and OEBC could partially fund behaviorists for a specific CCO, conduct a demonstration with the aforementioned patients, and then evaluate the results.
- 3) **Submit Grant applications** – The State of Oregon or specific CCOs could consider applying for a grant from foundations interested in either assisting states implement the ACA or mental health service delivery.
- 4) **Create a state mandate** – The state of Oregon could mandate that for a given number of patients, CCOs must have behaviorists in primary care settings.

Notes

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