DRAFT 5-31-18

CCO 2.0 Policy Development
Draft Policy Options – For Review by OHPB 6/5/18

Following is a list of the guiding questions, policy goals or themes, and potential options and strategies that have been explored as part of the CCO 2.0 policy development process. These policies have been publicly reviewed by experts, stakeholders, and partners from January to May 2018, and public input has been incorporated whenever possible. This list will be discussed at the June 5 Oregon Health Policy Board meeting.

Behavioral Health

BH – Guiding Questions	Policy Options/Goals	Potential Strategies	Key
How will we measure integration?	Improve integration of behavioral health care by 1**) establishing a definition** of integration; 2) **identifying metrics** to track milestones of integration; 3) **identifying expected outcomes** and measures.	• OHA to refine definition of integration and add to the CCO contract • Identify metrics to track milestones of integration by completing an active review of each CCOs plan to integrate services that incorporates a score for progress • Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics.	∞
	Enhance electronic health record (**EHR)** and health information technology **(HIT) to improve integration**	• Develop an incentive program to support BH providers' investments in EHR • Require CCOs support EHR adoption across behavioral health contracted providers • Require CCOs ensure contracted BH providers have access to technology that enables sharing patient information for care coordination • Require CCOs ensure contracted BH providers have access to timely hospital event notifications, and require CCO utilization of hospital event notifications	♦
How can we encourage	**Implement Behavioral Health Home recognition program**.	• Identify, promote and expand programs that integrate primary care in behavioral health settings	5 ∞

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BH – Guiding Questions	Policy Options/Goals	Potential Strategies	Key
investment in behavioral health and hold CCOs accountable for these investments?	**Address billing barriers** between physical and behavioral health	• Identify billing system and policy barriers that prevent BH providers from billing from a physical health setting • Develop payment methodologies to reimburse for warm handoffs, impromptu consultations and integrated care management services • Examine equality in BH and PH reimbursement • Implement strategies from existing workgroups that are addressing integrated billing barriers	5
	Align CCO procurement process and contracting with Oregon Performance Plan (OPP), Behavioral Health Collaborative (BHC) and Medicaid Waiver	• Clear ownership of BH benefit by the CCO • OPP to be included in 2019 CCO contract extension • BHC alignment will include standardized assessments, workforce retention and recruitment, core competencies for workforce, risk sharing with Oregon State Hospital • Mental health residential benefit and capacity management	∞ * ‡
	Establish **care coordination standards for integrated care**	• Require CCOs to ensure a care coordinator is identified for individuals with Severe and Persistent Mental Illness (SPMI) and for children with Serious Emotional Disturbances (SED) • Develop standards for care coordination • Establish outcome measure tool for Care Coordination	5 ∞ *
	Direct service providers are using **evidence-based practices and emerging practices**	• Update OHAs recommended clinical practices • Require outcome measures or metrics for research based practices • CCOs provide clinical trainings or funding to their provider network • Incentivize use of best practices and emerging practices	∞ *
How can we ensure that the system has the workforce to achieve expected outcomes?	Identify and implement culturally and linguistically specific best practices to ensure **access to and utilization of culturally and linguistically specific programs**	• Implement the Behavioral Health Collaborative recommendations: assessment of the BH workforce; update BH Mapping tool; recruitment and retention plan; competencies for integrated BH workforce; standardized suicide risk assessment • Require CCOs develop best practices to outreach to culturally specific populations • Develop a diverse behavioral health workforce who can provide culturally and linguistically appropriate care	5 ∞

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BH – Guiding Questions	Policy Options/Goals	Potential Strategies	Key
		• Implement the recommendations of the Traditional Health Workers Commission	
How do we ensure that children receive comprehensive behavioral health services no matter where they live in Oregon?	Ensure access to a behavioral health **continuum of care across the lifespan**	• Prioritize access to early intervention (0-5) • Develop mechanism to assess adequacy services across the continuum of care • Require CCOs ensure gaps in the continuum of care are addressed and that consumers have access to a diverse provider network	5 ∞
	Ensure there are ample incentives and opportunities to **work across systems**	• System of Care to be fully implemented for the children's system • Require Wraparound is available to all children and young adults who meet criteria • Incentivize CCOs to develop approaches to meeting the complex health needs of children and young adults	5 ∞
	Ensure there is a children's behavioral health system to **achieve measurable symptom reduction**	• CCOs require outcome measures tools from providers and have the ability to collect and report out on data • Fund CCOs for prevention services for children • OHA and CCOs develop a Train the Trainer investment in behavioral health models of care • CCOs, with the support of OHA, to incentivize providers to implement trauma informed care practices	5 *
	Ensure **special populations**, prioritizing children in Child Welfare, have their physical and behavioral health needs met by CCO and system of care	• Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD) • CCOs require providers to utilize ACEs score or trauma screening tools to develop individual service and support plans	5 ∞

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Social Determinants of Health and Health Equity

Health Equity/SDOH Questions	Policy Options/Goals	Potential Strategies	Key

How can OHA encourage CCOs to spend more in social determinants of health & health equity work, and hold CCOs accountable for their spending?	**Increase strategic spending by CCOs on social determinants of health and health equity/disparities** in communities, including encouraging effective community partnership.	• Implement HB 4018: Require CCOs to spend portion of savings on SDOH, population health policy and systems change & health equity/health disparities, consistent with the CCO community health improvement plan (CHP)
		  • Require CCOs to hold contracts with and direct portion of required SDOH&HE spending to SDOH partners through transparent process
		  • Require CCOs to designate role for CAC
		• Years 1 & 2 infrastructure grants: State provide two years of "seed money" to help CCOs meet spending requirement on SDOHE in partnership with community SDOH and CHP providers
		  • Require one statewide priority – housing-related supports and services – plus community priority(ies)
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	Increase strategic spending by CCOs on health-related services (HRS) as a mechanism to invest in the social determinants of health and equity in communities.	• Encourage HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans • Require CCOs' HRS policies to include a role for the CAC in making decisions about how community benefit HRS investments are made.	5 *
	Increase CCO's focus on SDOH and equity and **ensure community partners are engaged and resourced to support** this focus.	• Encourage adoption of SDOH, Health equity, and population health incentive measures to the Health Plan Quality Metrics Committee and Metrics & Scoring Committee for inclusion in the CCO quality pool • Encourage CCOs to share financial resources with non-clinical and public health providers for their contributions to incentive measures, through clarifying the intent that CCOs offer aligned incentives to both clinical AND non-clinical providers with quality pool measure areas	5 ♦ ∞ *

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Health Equity/SDOH Questions	Policy Options/Goals	Potential Strategies	Key
	Provide clear, common definition of social determinants of health, health equity, and related concepts to ensure clear boundaries for CCO spending and engagement in these areas.	• Consider, adopt and operationalize definitions of social determinants of health and social determinants of health equity, as developed by the Oregon Medicaid Advisory Committee • Work with the OHPB Health Equity Committee to consider/develop definitions of health equity and health disparities	∞
How do we strengthen CCO partnerships and ensure meaningful engagement to support social determinants of health & health equity work?	**Strengthen Community Advisory Council (CAC)/CCO partnerships** and ensure **meaningful engagement of diverse consumers** to support social determinants of health & equity work.	• Require CCOs to align CAC member composition with demographics of Medicaid members in their communities, report to OHA, and explain barriers to and efforts to increase alignment • Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, etc.) and percentage of CAC comprised of OHP consumers • Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the CAC connects to the CCO board • Require CCOs have 2 CAC representatives, at least one being an OHP consumer, on CCO board	5 ∞ *
	Improve health outcomes through community health assessment **(CHA)** and community health improvement plan (**CHP) collaboration and investment.**	• Require CCOs to develop shared CHAs with local public health authorities and non-profit hospitals • Require CCOs to collaborate with local public health authorities and non-profit hospitals to develop shared CHPs to the extent feasible • Ensure CCOs include organizations that address the social determinants of health and health equity in the development of the CHA/CHP • Require CCOs to submit their CHA to OHA • Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need	5 ∞ *
How do we better ensure provider	Development of **CCO internal infrastructure and investment** to coordinate and support CCO equity activities and build	• Each CCO will establish permanent structures to advance health equity, including: • Single point of accountability for health equity with budgetary decision making authority and health equity expertise.	5 ∞ *

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Health Equity/SDOH Questions	Policy Options/Goals	Potential Strategies	Key
cultural competency, language accessibility, a diversified workforce, and access to critical services across the state within a CCO and its provider network that reflects the population served by the CCO?	organizational capacity to advance health equity.	• Adoption of a Health Equity plan to institutionalize organizational commitment to health equity. • Organization-wide cultural responsiveness and implicit bias training fundamentals training plan and timeline for implementation	
	Enhance **integration and utilization of Traditional Health Workers** to ensure delivery of high quality, and culturally and linguistically appropriate care to improve health outcomes	• Implement recommendations of the THW Commission, including requiring CCOs to: • Create plan for integration and utilization of THWs • Incorporate alternative payment methods to establish sustainable payment rates for THW services • Integrate best practices for THW services in consultation with THW commission • Designate a CCO liaison as a central contact for THWs • Identify and include THW affiliated with organizations listed under ORS 414.627 in the development of CHAs and CHPs	5 ∞ *
	Reduce barriers to access for health services through **standardization of telehealth reimbursement requirements** across all CCOs.	• Require CCOs to reimburse for telehealth services, including two-way video conferencing and asynchronous methods if certain conditions are met • Require reimbursement regardless of patient being in a rural or urban setting	5 ∞
What changes in data collection/use can we make to improve our understanding of social determinants of health & equity initiatives and disparities?		To be determined during Phase 2 and 3 of CCO 2.0 Policy Development Timeline (June-November 2018) based upon further development and planning related to recommended strategies above.	5 ∞ *

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Cost Containment and Sustainable Spending

Guiding Questions:

- Is 3.4% still the proper growth target for the entire CCO 2.0 contract period?
- What cost drivers threaten achievement of sustainable growth rate (3.4%) in future years?
- What cost drivers warrant additional analysis to help OHA and CCO partners continue to meet growth targets?
- What strategies could increase CCO financial accountability while preserving flexibility to operate within global budget?

Cost - Policy Categories	Policy Goals	Potential Strategies	Key
Spending Targets and Cost Containment	Maintain an aggressive spending target in CCO contracts and promote cost containment by sharing savings with CCOs	1. Ongoing evaluation of Oregon's sustainable spending target based on national trends and emerging data 2. Shared-savings arrangements for achievement of lower-than-targeted spending growth • Designed in part to ensure CCOs have funding stream to continue investments that reduce underlying health care spending 3. Include sustainable growth target as a contract requirement to increase CCO accountability	
Promoting Efficiency and High Value Care	Overall policy goal: Incentivize CCO efficiency and promote the use of health care services with highest clinical value ***Supporting rationale:*** *Payments to CCOs,*	1. Evaluate efficiency and total costs of care to establish variable profit margins based on CCO performance • Potential tools include using episode groupers to evaluate care for specific conditions to identify waste and inefficiency in the system and using "total cost of care" tools to evaluate costs and service intensity/utilization across the system and compared to multiple benchmarks	

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	hospitals and other providers should reward and incentivize efficient delivery of care and use of services with highest clinical value	2. Incentivize health care services with highest clinical value by rewarding their use in rate setting • Identify health care services and bundles of care with highest and lowest clinical value through formal process that builds on our prioritized list • Give additional "credit" in capitation rate setting for higher clinical value care and less credit for lower-value services. ○ High value examples: medication-assisted treatment for opioid use disorder, diabetes prevention programs, integrated behavioral health, contraceptive placement, breastfeeding counseling & supplies, and tobacco cessation ○ Low-value examples: opioid use treatment w/o medication, stress tests in stable coronary disease, elective orthopedic surgery, and inappropriate tests and/or screenings outside clinical guidelines. 3. Increase the portion of hospital payments that are based on quality and value • Incorporate quality and value measures in calculating reimbursement to hospitals (includes CCO and OHA directed payments).	
Quality Pool Payments & Structure	Incentivize CCOs to invest quality pool funds on programs, providers and partners that improve quality and enable CCOs to achieve selected metrics, while ensuring accountability and reducing cost growth	1. Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development in order to: • Align incentives for CCOs, providers, and communities to achieve quality metrics • Create consistent reporting of all CCO expenses related to medical costs, incentive arrangements, and other payments regardless of funding source (Quality Pool or global budget)	

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Mitigating Financial Risk & Outlier Costs	Spread and manage risk related to low frequency, high-cost conditions and treatments	1. Establish a statewide reinsurance pool for CCOs administered by OHA to spread the impact of low frequency, high cost conditions and treatments across entire program 2. Expand / revise existing risk corridor programs • Value potentially limited to targeted conditions and/or services 3. Address increasing pharmacy costs and the impact of high-cost and new medications • Ongoing policy development & follow-up based on future OHPB committee	
Financial Reporting and Reserves	Enhance alignment of CCOs risk and financial requirements to ensure CCO solvency, accountability, and consistency of data	2. Enhance current reporting tools: A. Building on existing reporting templates (i.e., Exhibit L) and reevaluate reserve requirements and calculations to better account for risks CCOs bear ○ Home-grown and flexible to meet needs of CCOs with varying structures ○ Reconciliation to rate-setting process incorporated in reporting ○ Consistency across CCOs can be lacking due to inherent flexibility B. Move to reporting standards used by commercial insurers and developed by the National Association of Insurance Commissioners (NAIC) and use Risk Based Capital (RBC) approach to evaluate solvency ○ NAIC provides consistent national standards used by many insurers ○ RBC provides robust oversight framework ○ Additional reconciliation needed to inform CCO rate development C. Combination approach if possible 3. Create a statewide reserve pool in addition to CCO-specific reserve requirements in the event of an insolvency • Such a pool could avoid the need to CCOs receive additional funding to build up reserves, but could require up-front state funds.	

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Ensuring Accurate and Sufficient Encounter Data	Consistent and accurate reporting of services provided and their associated costs	1. Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy (AZ Model) with financial implications • Goal is to ensure the accuracy of encounter data, which is an important tool for the development of actuarially sound capitation rates for CCOs 2. Require complete encounter data with contract amounts and additional detail for value-based payment arrangements • With greater use of value-based payments and other alternative payment methodologies, new tools will be needed to ensure rate development processes take into account the services provided and the underlying costs of those services. • In absence of additional reporting, proxy values must be used and may not be as accurately reflective of the costs/value of services provided	

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Value-based Payments

VBP Guiding Questions	Policy Options/Goals	Potential Strategies	Key
How can OHA use VBP targets to encourage VBPs between CCOs and their providers, and hold CCOs accountable? *CCO payments to providers: Targets*	Increase **CCOs' use of VBPs with their contracted providers**	• Require CCOs to develop Patient-centered Primary Care Home VBPs (i.e., payments based on PCPCH tier level) • Require CCO-specific VBP targets in support of achieving a statewide VBP goal	∞ *

How can OHA encourage VBPs that foster improvements in key care delivery areas to achieve better health outcomes?
CCO payments to providers: Policy areas
	Increase the use of **VBPs to improve health outcomes** in key care delivery areas	• Require CCOs to implement one VBP focused on these key care delivery focus areas:
		  • Primary care
		  • Behavioral health integration
		  • Oral health integration
		  • Specialty care
		  • Hospitals
		  • Children's health care
		  • Maternity care
		• Publish CCO data on these VBPs
		• Provide technical assistance to CCOs
		• Potentially develop more robust VBP requirements in later years
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What changes to data collection are necessary to track progress on, and improve our	**Assess CCOs' progress** toward the statewide VBP	• Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting • Streamline reporting by using All Payer All Claims (APAC) database for VBP reporting	∞ *

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VBP Guiding Questions	Policy Options/Goals	Potential Strategies	Key
understanding of, VBP utilization? *CCO payments to providers: Data*	goal and CCO-specific VBP targets	• APAC already collects non-claims payments from commercial carriers. Modifying APAC to better align with the VBP effort and having CCOs report to APAC will allow for comparing VBP progress across the health system, including CCOs. • Collect supplemental data and / or interviews • Information not captured in quantitative data collection such as how CCOs' are addressing racial/ ethnic health disparities, what informed their models, longer term VBP goals, etc.	

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