

CCO 2.0 Policy Development Timeline

PHASE I Development of draft policy recommendations

PHASE II Review/refinement of policy recs

PHASE III Operationalizing recommendations

Online survey open for 2.0 feedback

Public input collected for policy development phase

3/15
Introductory
Webinar on CCO

Public Input on
proposed recs

Public input
summarized for
OHPB review

March April May June July August Sept Oct Nov Dec

2018

March 6
Oregon
Health
Policy
Board
(OHPB)

*Policy options reviewed and
discussed at existing public
committee meetings*

June 5 OHPB
EXTENDED
PUBLIC
COMMENT

*Statewide
Forums*

Aug 7
OHPB

Oct 2
OHPB

★ Topic Area
Work Plans
Developed

★ Review of policy
options

★ Policy
Proposal
Straw Model

★ CCO 2.0 Final
report approval

**March 1
Meeting:**
Overall
Timelines/
Structure
Presented

April 11 Meeting:

- Review tribal engagement plan
- Identify Tribes wanting 1:1 consultations
- Share work plans
- Request written feedback on any initial ideas they'd like for consideration

May Meeting:

Tribal webinars in each of the four topic areas on the policy options

★ Written
Comments
Due

**June/July Monthly
Meetings:**

- Review feedback from Tribes
- Discuss 1st straw proposal

*Individual 1:1 tribal
consultations*

August Meeting:

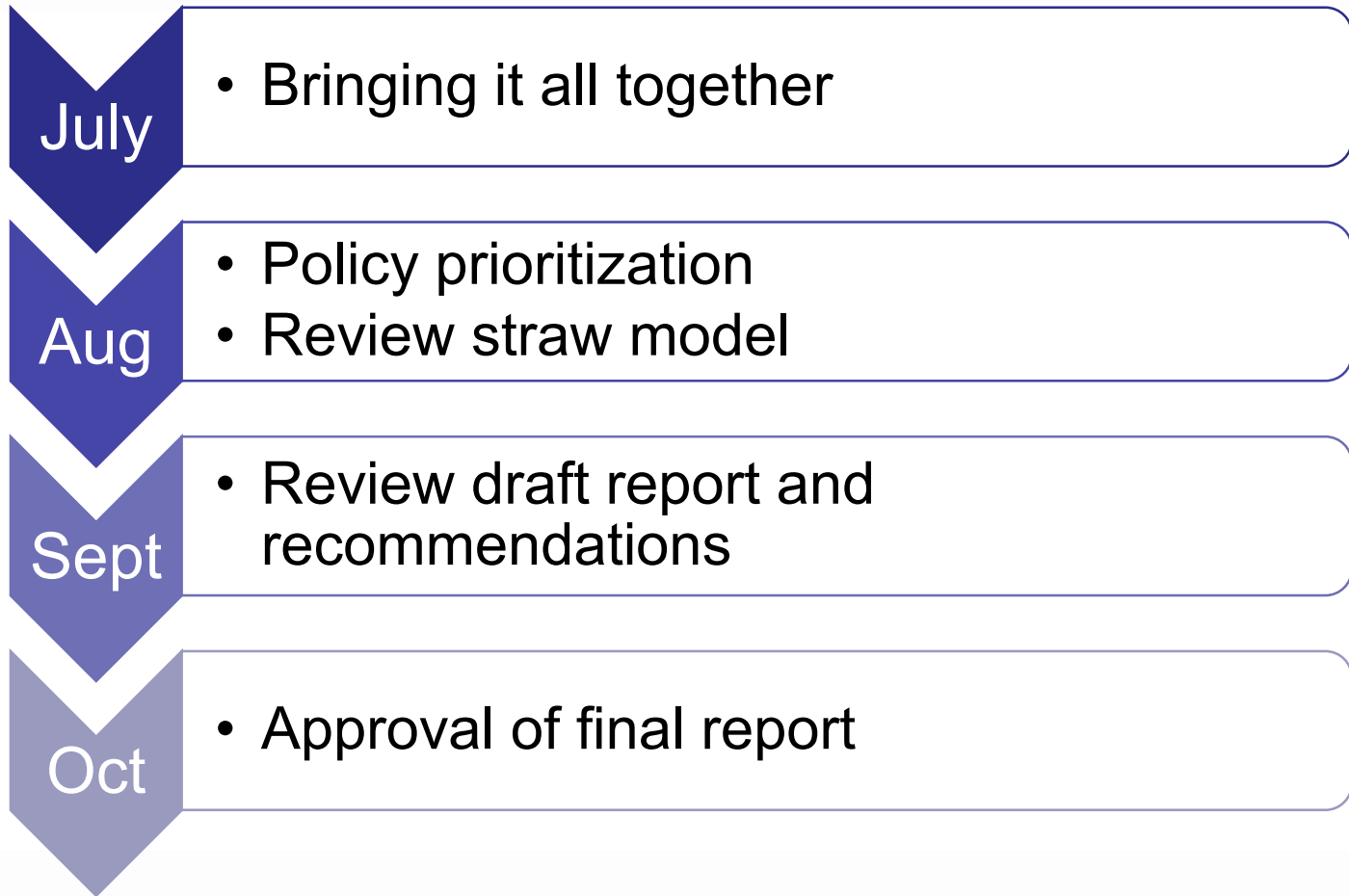
Review Straw Model

Public
Meetings

MILESTONES

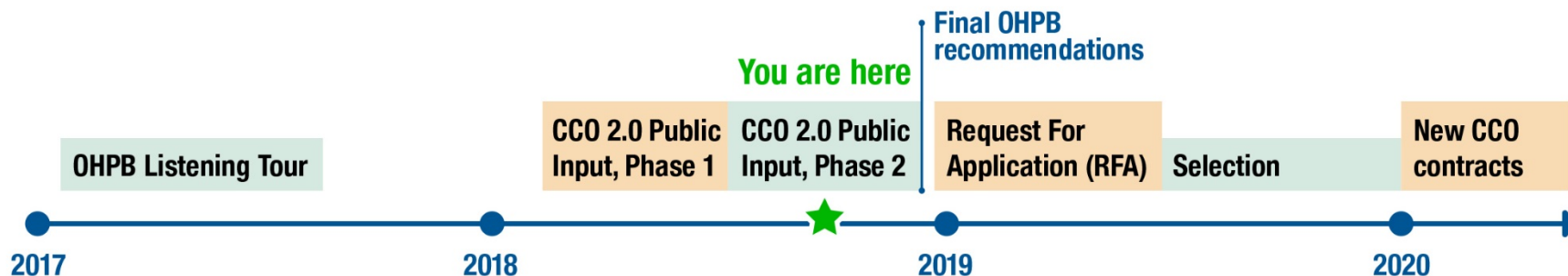
Tribal
Engagement

CCO 2.0 and OHPB: The big picture





CCO 2.0 timeline



CCOs will be selected through a Request for Application (RFA) process

- Only current CCOs and companies with an existing Oregon “footprint” can apply
- Considering asking applicants to apply for regions with an option for current CCOs to apply for their current service area

CCO 2.0

“straw model”

CCO 2.0 Straw Model

Organization of the straw model:

1.New policy ideas

- Year 1
- Year 2

2.Policies that currently exist in contract; needs strengthening or improved monitoring

3.Recommendations to/for OHA

4.Policies not recommended at this time

Reminder: Feasibility and Impact Analysis

- Feasibility – In general, how heavy is the “lift” for this policy across the system?**

	Generally easy/straightforward to implement, little to no additional work or resources required; is already part of the plan/expectation
	Requires moderate increase in staff time, resources, development, or funding; could face some challenges
	Will be a challenge to implement and will require new resources (e.g., funding, staff time, significant development, workgroups, etc.)

- Impact – In general, how much does this policy move the needle in achieving the goals of the model?**

	Plays a supporting role, offers some clarity or direction; will have a small impact on business practices
	Medium impact; policy will strengthen Oregon's direction and we'll see some type of effect across the state
	Fundamental to moving the needle in this area of the CCM, significant impact or transformational

How to read the straw model

- **Policy description:** What is the policy?
- **Intended Impact:** What are the outcomes or expected results of the policy?
- **Implementation:** How would this policy be put in place? Who is responsible?
- **Considerations:** [varies]
 - Timeline, support/opposition, evidence, best practices, current implementation, etc.

DASHBOARD EXAMPLE:

★	Fulfills state or federal mandate
Priority area:	BH
How heavy is lift?	● ● ●
How large is impact?	● ● ●
Equity	TBD – OEI/HEC
	2019 POP planned
	Requires legislation
✓	Potential to impact children
	May require OHA TA support
	Could have flexible timeline
	Increases transparency

Note: Impact on equity is currently being identified by the Office of Equity and Inclusion (OEI) in consultation with the Health Equity Committee (HEC) and other community partners. It will be incorporated in August 2018.



Governor Brown's Vision

The Governor has asked the Oregon Health Policy Board to provide recommendations in four areas for improving CCOs in the future:

- Maintain sustainable cost growth
- Increase value-based payments and pay for performance
- Focus on social determinants of health and equity
- Improve the behavioral health system

CCO 2.0 Final Report Framework & Reflections

CCO 2.0 Final Report Framework

Final report draft outline:

- Vision of CCO 2.0
- Goals of the coordinated care model
- Prioritized policy recommendations, including:
 - Any sequencing needed
 - Contract changes needed in year 1
 - Legislation or support needed from Legislature and Governor
 - Operational changes for OHA
- Appendices:
 - Additional goals and opportunities that have surfaced through this process (not necessarily CCO 2.0)
 - Promising policies that need additional development work
 - Housekeeping changes to contracts

For more information on CCO 2.0 visit:
www.health.oregon.gov

**Questions, comments, or
recommendations?**

Email CCO2.0@state.or.us

Thank you!



New Policy Ideas: Year 1																											
#	Policy	Dashboard	Intended impact	Implementation	Considerations																						
1	Implement HB 4018: Require CCOs to spend portion of savings on SDOH, population health policy and systems change, and health equity/health disparities, consistent with the CCO community health improvement plan (CHP) a) Require CCOs to hold contracts with and direct portion of required SDOH&HE spending to SDOH partners through transparent process b) Require CCOs to designate role for CAC in directing and tracking/reviewing spending. Years 1 and 2 infrastructure grants: State provide two years of “seed money” to help CCOs meet spending requirement on SDOH&HE in partnership with community SDOH and CHP providers Require one statewide priority – housing-related supports and services – in addition to community priority(ies)	<table><tr><td>★</td><td>Fulfills state or federal mandate</td></tr><tr><td>Priority area:</td><td>SDOH / Health Equity</td></tr><tr><td>How heavy is lift?</td><td>● ● ○</td></tr><tr><td>How large is impact?</td><td>● ● ●</td></tr><tr><td>Equity</td><td>TBD – OEI/HEC</td></tr><tr><td>✓</td><td>2019 POP planned (see note)</td></tr><tr><td></td><td>Requires legislation</td></tr><tr><td>✓</td><td>Potential to impact children</td></tr><tr><td>✓</td><td>May require OHA TA support</td></tr><tr><td></td><td>Could have flexible timeline</td></tr><tr><td>✓</td><td>Increases transparency</td></tr></table>	★	Fulfills state or federal mandate	Priority area:	SDOH / Health Equity	How heavy is lift?	● ● ○	How large is impact?	● ● ●	Equity	TBD – OEI/HEC	✓	2019 POP planned (see note)		Requires legislation	✓	Potential to impact children	✓	May require OHA TA support		Could have flexible timeline	✓	Increases transparency	Increased strategic spending by CCOs on social determinants of health and health equity/disparities. Decision-making is inclusive and consumer-informed.	- Mandated by HB 4018; seed money is not required but strongly recommended by OHA staff. - HPA and actuarial staff to develop investing guidelines and reporting and monitoring strategy - Compliance needed NOTE: POP is for a SDOH Transformation Analyst that would support a variety of SDOH work; could be applied to this policy option.	- Seed money proposed to be 0.5-1% of total global budget (prioritize seed money along with quality pool funds; amounts dependent on 2020 budget and operating under 3.4% growth cap) - Spending must align with CCO CHP priorities, TQS, waiver <u>Pros</u>: May encourage spending on health related services as key mechanism to track investments in SDOH; May encourage additional spending on SDOH within the global budget <u>Cons</u>: Could reduce funds flowing to clinical providers <u>Feedback</u>: - OHPB 7/10/18: Support for statewide priority of housing-related supports and services - CCO 2.0 Survey and MAC survey ranked housing as a top priority for SDOH work <u>Agency partnerships</u>: OHA is partnering with Oregon Housing and Community Services to expand supportive housing in the state, and there are particular opportunities to leverage this partnership to increase housing infrastructure in communities while expanding the housing-related services and supports that CCOs provide to complement this infrastructure.
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2	Increase strategic spending by CCOs on health-related services by: a) Encouraging HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans; and b) Requiring CCOs' HRS policies to include a role for the CAC in making decisions about how community benefit HRS investments are made.	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr><tr><td>Priority area:</td><td>SDOH / Health Equity</td></tr><tr><td>How heavy is lift?</td><td>● ● ○</td></tr><tr><td>How large is impact?</td><td>● ● ○</td></tr><tr><td>Equity</td><td>TBD – OEI/HEC</td></tr><tr><td></td><td>2019 POP planned</td></tr><tr><td></td><td>Requires legislation</td></tr><tr><td>✓</td><td>Potential to impact children</td></tr><tr><td>✓</td><td>May require OHA TA support</td></tr><tr><td>✓</td><td>Could have flexible timeline</td></tr><tr><td>✓</td><td>Increases transparency</td></tr></table>		Fulfills state or federal mandate	Priority area:	SDOH / Health Equity	How heavy is lift?	● ● ○	How large is impact?	● ● ○	Equity	TBD – OEI/HEC		2019 POP planned		Requires legislation	✓	Potential to impact children	✓	May require OHA TA support	✓	Could have flexible timeline	✓	Increases transparency	SDOH spending is aligned in communities and across various SDOH spending strategies. Community resources are used more efficiently. Decision-making is inclusive and consumer-informed.	- No contract changes (“encourage”) - Contract language change - OHA to develop guidance, FAQs to ensure clarity on HRS requirements	<u>Pros</u>: Leverages existing work and other SDOH spending requirements <u>Cons</u>: Competing priorities for investment
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3	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 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	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr><tr><td>Priority area:</td><td>SDOH / Health Equity</td></tr><tr><td>How heavy is lift?</td><td> </td><tr><td>How large is impact?</td><td> </td><tr><td>Equity</td><td>TBD – OEI/HEC</td></tr><tr><td></td><td>2019 POP planned</td></tr><tr><td></td><td>Requires legislation</td></tr><tr><td>✓</td><td>Potential to impact children</td></tr><tr><td>✓</td><td>May require OHA TA support</td></tr><tr><td>✓</td><td>Could have flexible timeline</td></tr><tr><td></td><td>Increases transparency</td></tr></tr></tr></table>		Fulfills state or federal mandate	Priority area:	SDOH / Health Equity	How heavy is lift?		How large is impact?		Equity	TBD – OEI/HEC		2019 POP planned		Requires legislation	✓	Potential to impact children	✓	May require OHA TA support	✓	Could have flexible timeline		Increases transparency	Community partners are engaged and receive financial resources for their contributions to achieving incentive measures. <i>Metrics:</i> CCO quality pool dollars are used to incentivize improvements in SDOH and health equity.	Policy could go into effect in Year 1 or Year 2 of CCO contract. Year 1 could be used for planning. Additional OHA resources needed: Staff FTE needed to assess current practices, develop tools and resources for CCO, non-clinical and public health providers to quantify contributions to achieving incentive metrics, and provide technical assistance. Staff FTE for planning, tool development and ongoing technical assistance are needed in HPA and PHD; monitoring/compliance also needed. <i>Metrics:</i> This can be implemented in Year 1 with no additional resources.	- Recommended by the Public Health Advisory Board (PHAB) - Support provided at road show forums. <u>Pros:</u> - Sets expectation that CCOs assess contributions of non-clinical and public health providers to achieving incentive measures, in addition to clinical providers, and pay for these contributions accordingly. - Maintains local flexibility for CCOs to work with specific providers in their communities that meaningfully contribute to meeting incentive measures. - May allow for better standardization for how non-clinical and public health providers are included in quality pool payment structures. <u>Cons:</u> As written, this policy option “encourages” rather than “requires”, which may lead to inconsistent approaches. However, there are concerns about requiring quality pool payments to a single provider type, which may have unintended consequences and set a precedent for similar requirements from other provider groups. Also, OHA staff believe there may be federal waiver or rule concerns related to requiring incentive payments to specific providers. <i>Metrics:</i> Current statute doesn’t allow OHA to require that either HPQMC or M&S take up specific measures or categories of measures. However, both committees are committed to this work.
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4	Strengthen community advisory council (CAC)/CCO partnerships and ensure meaningful engagement of diverse consumers through the following: a) 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; b) Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, education, etc.) and percentage of CAC comprised of OHP consumers; and	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr><tr><td>Priority area:</td><td>SDOH / Health Equity</td></tr><tr><td>How heavy is lift?</td><td> </td><tr><td>How large is impact?</td><td> </td><tr><td>Equity</td><td>TBD – OEI/HEC</td></tr><tr><td></td><td>2019 POP planned</td></tr><tr><td>✓</td><td>Requires legislation</td></tr><tr><td>✓</td><td>Potential to impact children</td></tr><tr><td>✓</td><td>May require OHA TA support</td></tr></tr></tr></table>		Fulfills state or federal mandate	Priority area:	SDOH / Health Equity	How heavy is lift?		How large is impact?		Equity	TBD – OEI/HEC		2019 POP planned	✓	Requires legislation	✓	Potential to impact children	✓	May require OHA TA support	CCOs have a representative CAC. This builds trust and relationship with members. Systems are designed with the member in mind.	Strongly recommended for Year 1, pending legislation. - OEI/TC further develop standards w/HEC’s guidance - HSD work needed to ensure better demographic data of CCO enrollment - TC capacity for TA and receiving and reviewing reports - Complexity of figuring out standards for representation and supporting CCOs/CACs to meet standards - Need to define OHP consumer	<u>Pros:</u> Supports better representation and meaningful engagement of consumers; Reporting requirements can be added to the TQS; Potential benefit to recruitment/retention (Elevate CAC due to role on board – part C) <u>Cons:</u> Potential recruitment and retention challenges (including possible resistance to CAC members reporting on their own demographic information to their CAC/CCO); Enrollment data issues/complexity (can use demographic data from American Community Survey or other sources as needed); Possible concern with information privacy and how much of that info is shared with the federal gov’t - Requiring alignment with communities came about from interest in supporting more diversity and better representation, but this specific policy option as worded did not come directly from CACs.				
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New Policy Ideas: Year 1

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	c) Require CCOs have two CAC representatives, at least one being an OHP consumer, on CCO board.	✓ Could have flexible timeline ✓ Increases transparency			Part C - Requiring CCOs to have more than one CAC representative on the board was included after interviews with key informants
5	Develop CCO internal infrastructure and investment to coordinate and support CCO equity activities by implementing the following: a) Require CCOs to adopt a Health Equity plan, including culturally and linguistically responsive practice, to institutionalize organizational commitment to health equity, b) Require a single point of accountability with budgetary decision-making authority and health equity expertise, and c) Require an organization-wide cultural responsiveness and implicit bias fundamentals training plan and timeline for implementation.	Fulfills state or federal mandate Priority area: SDOH / Health Equity How heavy is lift? ● ○ ○ How large is impact? ● ● ○ Equity TBD – OEI/HEC 2019 POP planned Requires legislation ✓ Potential to impact children ✓ May require OHA TA support ✓ Could have flexible timeline ✓ Increases transparency	Standardization of health equity infrastructure in CCOs. Equitable expertise and infrastructure to facilitate adoption of measures to reduce health disparities	- Work led by OEI, and the Health Equity Committee will provide a framework for the health equity plan. OHA to staff/lead a work group that will develop health equity plan guidelines for CCOs. - OEI to develop training fundamentals plan guidance document. - Compliance needed.	- The lack of detailed tracking mechanisms and data related to health equity contributes to the challenge of understanding how CCOs have impacted these areas over the last five years. The infrastructure proposed will facilitate standarization and will ease the provision of TA by OHA. - Some CCOs have developed a strong organizational infrastructure for health equity, others have not; this represents an inequity. - The development of CCO internal infrastructure and investment to coordinate and support CCO equity is neccessary to ensure a) CCOs around the state are moving in the same direction; b) OHA and OHPB have a conduit to connect with CCOs on health equity activities, build learning collaboratives, and provide guidance and technical assistance; c) Health Equity infrastructure will facilitate the deployment of health equity metrics once they are developed. - Health equity infrastructure refers to culturally and linguistically responsive models, policies and practice including and not limited to language access, workforce diversity, ADA compliance and accessibility, ACA 1557 compliance, training and development, implementation of the CLAS Standards, non-discrimination etc.
6	Implement recommendations of the THW Commission: a) Require CCOs to create a plan for integration and utilization of THWs. b) Require CCOs to integrate best practices for THW services in consultation with THW commission c) Require CCOs to designate a CCO liaison as a central contact for THWs d) Identify and include THW affiliated with organizations listed under ORS 414.629 (Note that d. is also included under Policy Option 8 for CHAs/CHPs) e) Require CCOs to incorporate alternative payment methods to establish sustainable payment rates for traditional health workers (THW) services.	★ Fulfills state or federal mandate Priority area: SDOH / Health Equity How heavy is lift? ● ● ○ How large is impact? ● ● ● Equity TBD – OEI/HEC 2019 POP planned Requires legislation ✓ Potential to impact children ✓ May require OHA TA support ✓ Could have flexible timeline ✓ Increases transparency	Increases THW workforce by setting up a livable and equitable payment system; Increases access to peventive, high-quality care beyond clinical setting and improves outcomes Increases access to culturally and linguistically diverse providers	Implementation of a), b) and c) will start in Year 1 of the contract. Implementation of d) will coincide with CHA & CHP timeline. (see Policy 8) CCOs will work with THW Commission, OEI and HSD to: - Designate CCO liaison - Develop integration/ utilization plan with metrics to track integration milestones w/score for progress - Determine centralized/ standard reimbursement rates for reimbursement utilizing the Payment Models Grid created by the THW	Recommendation of the THW Commission: Builds upon THW services requirements already in contract. - Strong support came from health systems , health insurance carriers such as Providence, Care Oregon, Kaiser, OPCA and other CBOs, FQHCs - Need to dedicate necessary resources to ensure policies are adequately and appropriately staffed, monitored, and enforced. - The integration and utilization plan fulfills the mandates established by the following legislation: HB 3650 (2011), HB 3311 (2011), SB 1580 (2012), HB 3407 (2013)) & HB 2304 (2017). - Literature shows improved health outcome for consumers, which, in return, saves money for OHA through Medicaid programs. Positive return on investment with increased number and utilization of THWs - Payment Model Grid contains a variety of pathways for THW payment Including APM, bundling, value-based payment, and per-member-per-month payment for THW services, Fee for Service, Grants/Contracts,

New Policy Ideas: Year 1																											
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			beyond clinical setting.	Commision Payment Model Committee	Pathways, Medicaid administrative, targeted case and direct employment.																						
7	Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the Community Advisory Council connects to the CCO board	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr><tr><td>Priority area:</td><td>SDOH / Health Equity</td></tr><tr><td>How heavy is lift?</td><td> </td><tr><td>How large is impact?</td><td> </td><tr><td>Equity</td><td>TBD – OEI/HEC</td></tr><tr><td></td><td>2019 POP planned</td></tr><tr><td></td><td>Requires legislation</td></tr><tr><td></td><td>Potential to impact children</td></tr><tr><td></td><td>May require OHA TA support</td></tr><tr><td>✓</td><td>Could have flexible timeline</td></tr><tr><td>✓</td><td>Increases transparency</td></tr></tr></tr></table>		Fulfills state or federal mandate	Priority area:	SDOH / Health Equity	How heavy is lift?		How large is impact?		Equity	TBD – OEI/HEC		2019 POP planned		Requires legislation		Potential to impact children		May require OHA TA support	✓	Could have flexible timeline	✓	Increases transparency	Transparency on fulfillment of statutory requirement	TC staff: Monitoring in TQS	Reporting can be added to the Transformation and Quality Strategy (TQS)
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8	Require CCOs to partner with local public health authorities, non-profit hospitals, and any CCO that shares a portion of its service area to develop shared CHAs and shared CHP priorities and strategies. a) Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need. Ensure CCOs include organizations that address the social determinants of health and health equity in the development of the CHA/CHP, including THWs affiliated with organizations listed under ORS 414.629.	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr><tr><td>Priority area:</td><td>SDOH / Health Equity</td></tr><tr><td>How heavy is lift?</td><td> </td><tr><td>How large is impact?</td><td> </td><tr><td>Equity</td><td>TBD – OEI/HEC</td></tr><tr><td></td><td>2019 POP planned</td></tr><tr><td></td><td>Requires legislation</td></tr><tr><td>✓</td><td>Potential to impact children</td></tr><tr><td>✓</td><td>May require OHA TA support</td></tr><tr><td>✓</td><td>Could have flexible timeline</td></tr><tr><td></td><td>Increases transparency</td></tr></tr></tr></table>		Fulfills state or federal mandate	Priority area:	SDOH / Health Equity	How heavy is lift?		How large is impact?		Equity	TBD – OEI/HEC		2019 POP planned		Requires legislation	✓	Potential to impact children	✓	May require OHA TA support	✓	Could have flexible timeline		Increases transparency	Improved population health outcomes through CHA and CHP collaboration and investment. CHAs and CHPs that reflect the needs and priorities of the entire community. Reduced burden for community members due to streamlined community assessment and planning processes.	- Contract changes and rules changes needed. - Needs to be in contract for year one; work would phase in. CCOs would be required to meet these policy requirements with new CHAs and CHPs developed during the 2020-25 contract period (i.e. next CHA/CHP cycle). - OHA could convene a workgroup in Year 1 of the contract to develop recommendations for addressing barriers to shared CHAs and shared CHP priorities and strategies. This would build upon the work of the 2014 OHA CHA/CHP alignment work group.	Shared CHAs and shared CHP priorities and strategies: Recommended by the Public Health Advisory Board. Supported by OHPB at June meeting. Supported during road show forums. - Likely to reduce burden on community members who are asked to participate in multiple health assessments. Will reflect the needs of entire community, beyond Medicaid. Challenges with shared CHP development can be addressed through implementation and contractual requirements. SHIP priority alignment: Recommended by OHA staff. Support voiced by OHPB at 7/10 meeting. - High level of alignment currently between CHPs and 2015-19 SHIP. All CCOs could meet requirement with 2015-19 SHIP priorities (new SHIP for 2020-24). Ohio and New York have implemented similar requirements. May result in statewide gains on health conditions. Including orgs that address SDOH and health equity: Recommended by the Traditional Health Worker Commission (see policy option 2-2d) - Will ensure the voice of consumers experiencing health disparities into the community health assessment and planning process. May create a small limitation on local flexibility by prescribing the organizations to be involved.
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#	Policy	Dashboard		Intended impact	Implementation	Considerations
					- Staff FTE for TA would sit in HPA and PHD. - Staff FTE for monitoring and compliance in HSD.	
9	Require CCOs to submit their community health assessment (CHA) to OHA	Fulfills state or federal mandate		Transparency and support of community partner efforts.	- Should be included in contract from Year 1. Would go into effect at first CHA cycle in 2020-2025 contract period. - Monitoring is very straightforward (existing Transformation Center capacity)	- Origin of recommendation: OHA Transformation Center <u>Pros</u>: Promotes transparency and can allow for improved technical assistance to CCOs <u>Cons</u>: Would add a deliverable to CCO contract, but by rule CHAs are already required so it should be very easy for a CCO to submit their documentation to OHA
		Priority area: SDOH / Health Equity				
		How heavy is lift?				
		How large is impact?				
		Equity	TBD – OEI/HEC			
		2019 POP planned				
		Requires legislation				
Potential to impact children						
May require OHA TA support						
✓ Could have flexible timeline						
✓ Increases transparency						
10	Require CCO-specific VBP targets in support of achieving a statewide VBP goal	★ Fulfills state or federal mandate		Each CCO will be responsible for meeting annual VBP growth target calculated with their own baseline VBP data. This will ensure that all CCOs increase their use of VBPs.	NOTE: All CCOs will need to demonstrate a minimum of 20% VBP in primary care in RFA. - Year 1 (2020): Each CCO will be expected to achieve a 1-year VBP growth target tied to the statewide VBP goal and the CCO’s baseline data for category 2C (“performance-based incentive payments”) and category 3B (“shared risk”) as reported in their RFA response. - At end of the 1-year period, OHA will assess CCOs’ progress toward meeting growth targets and establish CCO-specific	- Statewide goal of CCO VBPs to providers; aligned with the 1115 waiver requirement. - Preliminary data collection of CCO VBP data indicates approximately 50% of CCOs’ payments to providers were at least in category 2C/pay-for-performance (which is similar to the CCO incentive metric program). - Statewide goal: sufficiently high to serve as a statewide goal, but not so high that it would be unachievable. - CCOs’ progress will apply to 70% statewide VBP goal progress. - CCOs already at high VBP % can advance in model sophistication or care delivery focus areas (e.g., increase their % in 3B/shared risk, or adopt a VBP to focus on behavioral health integration). - Potentially, develop CCO VBP collaborative to align efforts and share tools to lead this work in their communities. The CCO VBP collaborative could evolve into a multi-payer collaborative in later years.
		Priority area: VBP				
		How heavy is lift?				
		How large is impact?				
		Equity	TBD – OEI/HEC			
		✓ 2019 POP planned				
		Requires legislation				
		✓ Potential to impact children				
		✓ May require OHA TA support				
		Could have flexible timeline				
Increases transparency						
		Waiver requirement				

New Policy Ideas: Year 1					
#	Policy	Dashboard	Intended impact	Implementation	Considerations
				growth targets for years two–five. Statewide VBP goal of 70% of the weighted average of all CCOs’ payments to all providers will be achieved by the end of the CCO 2.0 period.	
11	VBP data reporting: - Report VBP data via All Payer All Claims (APAC) database - Supplemental VBP data and /or interviews - Require complete encounter data with contract amounts and additional detail for VBP arrangements	★ Fulfills state or federal mandate Priority area: VBP How heavy is lift? ●●● How large is impact? ●●● Equity TBD – OEI/HEC 2019 POP planned Requires legislation ✓ Potential to impact children ✓ May require OHA TA support ✓ Could have flexible timeline ✓ Increases transparency	CCOs reporting to APAC will allow for comparing CCO VBP progress over time, across CCOs and across the health system. Collecting supplemental data and/or interviews will provide important info not captured in APAC, such as how CCOs address racial/ethnic health disparities, what informed the development of their models, longer term VBP goals, etc.	NOTE: CCOs are required to report to APAC beginning in 2019 (and have been notified). Modification of APAC Appendix G will occur in 2019 and APAC Appendix G VBP reporting will begin in 2020.	1115 waiver requires reporting of CCO VBP data. - VBP data is not adequately captured in existing CCO reporting. - APAC already collects non-claims payments from commercial carriers. Modifying APAC to better align with VBP efforts and having CCOs report to APAC will allow for comparing VBP progress across the health system, including CCOs.
12	Require CCOs to develop Patient-centered Primary Care Home VBPs (i.e., payments based on PCPCH tier level)	Fulfills state or federal mandate Priority area: VBP How heavy is lift? ●●● How large is impact? ●●●	Provides financial support for PCPCHs to implement and sustain a robust PCPCH model of care.	Would require CCOs to pay PCPCHs a PMPM payment by PCPCH tier level, beginning year 1.	- Requires the use of a VBP to invest in a PCPCHs, which a 2016 evaluation showed have achieved better health outcomes and cost savings - Allows for advancement and sustainability of the PCPCH model - Aligned with CPC+ payment methodology, a national CMS, multi-payer primary care payment reform program

New Policy Ideas: Year 1						
#	Policy	Dashboard		Intended impact	Implementation	Considerations
		Equity	TBD – OEI/HEC	Supports staff and activities not reimbursed through FFS.		
			2019 POP planned			
			Requires legislation			
		✓	Potential to impact children			
		✓	May require OHA TA support			
		✓	Could have flexible timeline			
			Increases transparency			
13	Evaluate CCO performance with tools to evaluate CCO efficiency, effective use of health-related services (HRS), and the relative clinical value of services delivered through the CCO. Use evaluation to set a performance-based profit at individual CCO level.	★	Fulfills state or federal mandate	Improved delivery of benefits to CCO members including more efficient use of medical services, increased delivery of high-value services and increased use of HRS that improves member health	- Evaluation methodology implemented in 2020 (year 1) but 2021 likely first year CCO profits will be individually determined based on performance evaluation - Methodology to establish performance-based profit needs to be finalized, and could benefit from cross-agency workgroup. Methodology will consider efficiency, effective HRS investment, and clinical value of services delivered. - Methodology development needed in multiple phase and additional OHA staff likely needed	Policy is required as part of our current 1115 waiver - CCO-specific profit margins required by 2017 waiver renewal - Waiver language specifically calls out goal of variable profit to motivate effective HRS use by CCOs, but additional evaluation tools likely needed - Methodology to inform CCO-specific profit levels will be closely watched by stakeholders - Evaluation and analysis may require additional staff beyond current capacity (similar structure to HPA metrics team) - OHA could strategically choose to include this program in legislation for the upcoming session - Can be seen as more rigorous & formalized process to evaluate and achieve efficiency in managed care - Could result in base data exclusions of inefficiencies NOTE: Policy option now incorporates policy option to provide rewards for care with higher clinical value in rate-setting process.
		Priority area:	COST			
		How heavy is lift?	● ● ○			
		How large is impact?	● ● ○			
		Equity	TBD – OEI/HEC			
		✓	2019 POP planned			
			Requires legislation			
		✓	Potential to impact children			
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New Policy Ideas: Year 1																	
#	Policy	Dashboard	Intended impact	Implementation	Considerations												
14	Incorporate measures of quality & value in any OHA-directed payments to providers (e.g. hospital payments) and align measures with CCO metrics Example: qualified directed payments made directly to hospitals are based in part on quality and value	<table><tr><td>★</td><td>Fulfills state or federal mandate</td></tr></table>	★	Fulfills state or federal mandate	Providers are rewarded for improving value and quiality of care, and metrics for CCOs and other providers are aligned and coordinated to achieve maximum impact	- Implementation goal in 2020 - Additional policy development needed to establish the quality & value metrics to be used and their impact on specific payment streams - Alignment across CCOs and hospital quality metrics is key to CCO 2.0 - Implementation of quality / value metrics should build on HTPP experience - Requires policy development coordination between HPA, Finance, and HSD	Designed to meet CMS requirements related to pass-through funds that require OHA to move to a Qualified Directed Payment (QDP) process that includes quality/value - Policy involves hospital provider tax funds which adds to complexity & visibility - OHA could strategically choose to include this program in legislation for the upcoming session, or as part of the budge process - Connects and builds on other policy options to expand CCO use of VBPs										
		★	Fulfills state or federal mandate														
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15	Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development 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)	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	CCOs invest their quality pool earnings in a timely manner on the providers and partners who help achieve targeted metrics, and focus additional efforts on achieving targets to ensure maximim quality pool earnings	2020 capitation rates would reflect the quality pool as being funded by a withhold of capitation payments instead of as a bonus - Adjusting the operation to a withhold allows OHA the flexiblity to increase the percentage of revenue tied to quality and value - Requires policy development coordination between HPA, Finance, and HSD	- Some CCOs have expressed concern that their failure to achieve quality pool earnings in one year effectively limits their rates for the following year – additional methodology development should seek to alleviate concerns - Moving quality pool inside rates allows for creation of bonus funding methodology for social determinants of health funding - Creates consistent reporting of all CCO expenses related to medical costs, incentive arrangements and other payments regardless of funding source (global budget or quality pool)										
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New Policy Ideas: Year 1						
#	Policy	Dashboard		Intended impact	Implementation	Considerations
16	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			OHA has the flexibility and tools necessary to better manage patients with high-cost conditions, which will better enable OHA and CCOs to control program-wide costs associated with these patients	Staff recommends establishing this reinsurance pool for CCO 2.0; subject to a detailed financial viability analysis as part of the procurement rate process for 2020 and Legislative Budget process - Initial study needed to assess financial viability & costs associated with a state-backed reinsurance pool that would feed into the legislation - Additional policy development ongoing related to potential need for legislation (currently viewed as a need) and the type of federal sign-off needed - Timeframe for implementation is year 2+. Implementation could be phased in and program modified over several years based on experience if year 1 is not feasible.	Initial phase of implementation would be OHA responsibility. - Legislation likely needed to fully launch program - Helps fulfil goals of keeping OHP clients in CCOs and not open card - Short term benefits include spreading risk across CCOs and mitigating CCO risk associated with low-frequency, high-cost patients - Long term benefits could include reduced costs from using program-wide purchasing power and could build on efforts to better align PDLs - Connects to rate setting – potential budget risks in short term, ability to remove catastrophic claims from rate-setting reduces rate volatility, especially for small CCOs - DCBS received 1332 waiver to establish a reinsurance program for private carriers could be a resource
			Fulfills state or federal mandate			
		Priority area:	COST			
		How heavy is lift?				
		How large is impact?				
		Equity	TBD – OEI/HEC			
		✓	2019 POP planned			
		✓	Requires legislation			
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✓	Could have flexible timeline					
	Increases transparency					

New Policy Ideas: Year 1						
#	Policy	Dashboard		Intended impact	Implementation	Considerations
17	Address increasing pharmacy costs and the impact of high-cost and new medications by: increasing transparency of CCOs and their Pharmacy Benefit Managers and increasing alignment of FFS and CCO PDLs (based on recommendations from outside analysis and additional OHA/OHPB guidance)			Increased transparency of pharmacy costs and spending and increased alignment of PDLs provides new tools to OHA and CCOs to reduce pharmacy costs and ensure consistent access to pharmacy services for members across CCOs	- Transparency provisions could be implemented as broad requirements for how CCOs structure their PBM agreements, could be included in initial RFA and in CCO contracts - Recommendation is to take an incremental approach to strategically and partially align PDLs (ie, starting with slected drugs / classes and building on experience over time) - More specific aspects of the policy options will be informed by third-party analysis currently underway as well as additional policy development	- Varied opinion within CCO community on value/impact of proposed PDL policy - PDL recommendation is informed by outside analysis being presented to OHPB in August 2018 - Ongoing pharmacy policy recommendations may be informed by task force created by HB 4005 (in 2018 session) - Implementing a flexible reinsurance program in CCO 2.0 may help support this policy
			Fulfills state or federal mandate			
		Priority area:	COST			
		How heavy is lift?				
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		Equity	TBD – OEI/HEC			
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			Requires legislation			
			Potential to impact children			
		✓	May require OHA TA support			
✓	Could have flexible timeline					
✓	Increases transparency					
18	Enhance current financial reporting and solvency evaluation tools by moving to the financial reporting standards used by the National Association of Insurance Commissioners (NAIC) and the associated Risk Based Capital (RBS) tool to evaluate carrier solvency			Increase solvency protection and reduce risks to the state associated with a CCO insolvency event	- Use NAIC financial reporting templates and modify insurance regulations to fit unique CCO program including supplemental CCO-specific schedules; - Use RBC tool in evaluation of CCO solvency and consider increases to CCO reserves over the five year contract - Work with DCBS to build in a financial oversight framework that leverages the insurance code - Reporting framework requirements would be implemented in year 1, but Phased-in compliance with potentially higher reserve thresholds could be considered	- Phase-in implementation is preferred since NAIC requires new standards that will require CCOs to adjust financial reporting. - RBC thresholds need to be set for Medicaid if this tool is used to assess financial risk and reserves levels. - NAIC reports cover a two-year period and requires a five-year historical data period – OHA will need to decide the reporting timing for both the RFA and for the five-year contract based on this guidance. - OHA will need to become a NAIC member. - Potential impact to OHA and DCBS oversight capacity helps increase the “lift” score. - Approach is consistent with larger trends in Medicaid managed care including a patient and contractor makeup that more closely resembles the commercial insurance world. - Alternative is to enhance current exhibit L reporting tools.
			Fulfills state or federal mandate			
		Priority area:	COST			
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New Policy Ideas: Year 1					
#	Policy	Dashboard	Intended impact	Implementation	Considerations
19	Create a statewide reserve pool in addition to CCO-specific reserve requirements in the event of an insolvency (if move to NAIC or other changes increase required reserves from CCOs)	Fulfills state or federal mandate	Adequate financial resources are available to ensure potential CCO insolvency would not harm patient access to health care services or provider reimbursement for services delivered	- Option is connected to proposed move to NAIC reporting standards - Option is a potential funding source for increased reserve requirements - Additional policy development needed from finance and HPA	- Policy option connected to potential for NAIC/RBS requirements to increase required reserves for CCOs - Social funding of reserves could mitigate CCO costs related to increased reserve requirements in CCO 2.0 - Potential sharing of the reserves pool with the reinsurance program - Policy option requires CCO input and to-date OHA has received minimal input on this option <u>Pros</u>: Provides resource to fund greater reserves for CCOs <u>Cons</u>: Requires funding. Some risks in using state funds for reserves tied to private CCOs
		Priority area: COST			
		How heavy is lift?			
		How large is impact?			
		Equity TBD – OEI/HEC			
20	Require CCOs be fully accountable for the behavioral health benefit of their members as described in their contracts and not fully transfer the benefit to another entity. This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.	Fulfills state or federal mandate	CCOs fully accountable for members’ BH care. Increase access to BH services, decreased wait times, allow members provider choice, improve behavioral health outcomes for all Oregonians	- OHA will need to develop monitoring and compliance protocol for CCOs - Monitoring and compliance should be in HSD	- Integration of the behavioral health benefit should promote delivery of the behavioral health benefit. This means that the CCO is responsible for ensuring there is an adequate provider network, that members have access to behavioral health care, and that the CCO is responsible for outcomes. <u>Pros</u>: Clear owner of the behavioral health benefit for OHA and member <u>Cons</u>: Current CCOs may not have the expertise or infrastructure - This policy was developed from feedback regarding what is not currently working. Many stakeholders have called for the elimination of carve-outs; however, that may have unintended consequences. - Oregon Academy of Family Physicians states that carve outs "if allowed to exist at all in the future - should not be allowed for primary care behavioral health services;" NAMI, Children's Health Alliance and the Oregon Center for Children and Youth with Special Health Needs support elimination of carve-outs.
		Priority area: BH			
		How heavy is lift?			
		How large is impact?			
		Equity TBD – OEI/HEC			
		✓ 2019 POP planned			
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✓ Increases transparency					

New Policy Ideas: Year 1																	
#	Policy	Dashboard	Intended impact	Implementation	Considerations												
21	Identify metrics to track milestones of behavioral health (BH) and oral health (OH) integration with physical health care by completing an active review of each CCOs plan to integrate services that incorporates a score for progress - OHA to refine definitions of BH and OH integration and add to the CCO contract - Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Increase integration, increase access, increase provider network, decrease wait time	- Transformation Center (TC) has contracted with a consultant to identify the metrics and a review proposal - HSD and HPA will collaborate: HPA will monitor and pull data; the review will sit in HSD for compliance; TC will provide TA	- Behavioral health has not consistently been integrated by the CCOs. This will be a lever to ensure CCOs integrate services, for OHA to measure progress and to target technical assistance. - Children's Health Alliance supports and recommends that measurement recognizes appropriate measures for pediatric population; Oregon Medical Association supports quality incentive metrics for integration; Trillium supports.										
			Fulfills state or federal mandate														
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22	Identify, promote and expand programs that integrate primary care in behavioral health settings (Behavioral Health Homes)	<table><tr><td>★</td><td>Fulfills state or federal mandate</td></tr></table>	★	Fulfills state or federal mandate	Improve health outcomes; increase access to BH and PH	- Standards and ORS were completed under SB 832 - Would require hiring 3 FTE - Work would be within PCPCH program in HPA	SB 832 created the BHH, but there was no funding to implement - This would enable OHA to identify, promote and expand programs that integrate primary care in behavioral health settings. This will improve whole health outcomes for individuals - AOCMHP supports										
		★	Fulfills state or federal mandate														
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23	Require CCOs report on capacity and diversity of the medical, behavioral and oral health workforce within their geographical area and provider network. CCOs must monitor their provider network to ensure parity with their membership.		Fulfills state or federal mandate	Increase workforce to ensure network adequacy; increase access and outcomes for Oregonians	- HPA to develop report - HPA and HSD to monitor compliance	- This was first suggested in the HCWF by the Medical Director of a CCO while the committee was looking at challenges of collecting data on workforce capacity - This policy can contribute to the development of a shared accountability model for the adequacy of the health care workforce in the state between the CCOs and OHA (and potentially others) - Best practices in this area can be reviewed to help with developing the forms and review process
		Priority area:	BH			
		How heavy is lift?				
		How large is impact?				
		Equity	TBD – OEI/HEC			
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24	Require CCOs utilize best practices to outreach to culturally specific populations , including development of a diverse behavioral and oral health workforce who can provide culturally and linguistically appropriate care (including utilization of THWs)		Fulfills state or federal mandate	Improve health outcomes for culturally specific populations	- Guidelines and best practices being developed by OEI - Technical assistance recommended for implementation	- Guidelines and best practices need to be developed by OHA (OEI and BH) - Will require ongoing monitoring and TA
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New Policy Ideas: Year 1																	
#	Policy	Dashboard	Intended impact	Implementation	Considerations												
25	Prioritize access to Social-Emotional developmental services, health services, Early Intervention and targeted supportive services, and Behavioral health/mental health treatment for children ages birth through five years.	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Improve health outcomes for children	- CCOs to require and implement social-emotional screening for all children birth through five years in PCP setting - CCO’s would pay for Mental Health Consultation in early learning settings for their network of providers	- Fulfills a mandate: early learning hubs. Connects with recommendations of Governor’s Children’s Cabinet. - Two or more ACEs is associated with poor kindergarten and behavioral outcomes - Intervening early prevents poor long-term outcomes and reduces costs - Currently social-emotional screening is needed to identify children with problems interfering with kindergarten readiness and issues related to early behavioral health intervention needs										
			Fulfills state or federal mandate														
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26	Implement risk-sharing with the Oregon State Hospital (Behavioral Health Collaborative recommendation)	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	As CCOs assume risk we anticipate increase in community care and decrease in hospitalizations	- OHA has convened a risk sharing work group of external stakeholders to develop this BHC recommendation - Work will ultimately sit in HSD	- Behavioral Health Collaborative recommendation - This will advance the Oregon Performance Plan by facilitating community placement for individuals transitioning from Oregon State Hospital - May pose challenges in Multnomah County for hospitals regarding utilization review - CCO and CMHP support; AOCMHP supports; Care Oregon supports										
			Fulfills state or federal mandate														
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27	Shift financial role for statewide HIT public/private partnership from OHA to CCOs to cover their fair share	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	CCOs are directly connected to cross-stakeholder efforts (such as EDIE and PDMP Integration) to prioritize and improve HIT statewide	Timing – this would be an attestation in the RFA and contractual obligation starting with 2020 contracts. The only change needed is for CCOs to take over paying the HIT Commons dues that OHA is currently paying on their behalf. A dues schedule has already been established, current CCOs have signed MOUs to participate that includes transparency about taking on dues in 2020, and CCOs are participating in HIT Commons efforts and have 3 seats on the HIT Commons Governance Board. OHIT manages this work.	<u>Pro</u>: HIT Commons continues to support CCO and Medicaid objectives and is informed about the needs of Oregonians across the state. Ensuring CCO participation will demonstrate value to other stakeholders and help ensure the HIT Commons maintains sufficient participation for effective governance of statewide HIT initiatives. <u>Con</u>: Some CCOs may prefer to focus on local HIT initiatives in the future. <u>Consideration</u>: 2018 dues range from \$1,300 for the smallest CCO to \$70,100 for the largest. Dues are paid using FMAP-eligible funds. <u>Feedback</u>: Stakeholders have had little feedback other than requesting information about the dues – this has been non-controversial.					
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28	Standardize CCO coverage for telehealth services: CCOs must cover telehealth services offered by contracted providers if those same services are covered when delivered in-person, regardless of a patient’s geographic setting (rural, urban). Coverage would include asynchronous communications if there is limited ability to use videoconferencing. This proposal does not address the availability of telehealth services (i.e., does not require CCOs to add new providers to ensure telehealth is broadly available), but focuses on coverage.	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Reduced barriers to telehealth services, better access to specialty and behavioral health care in frontier/rural areas, and reduced health disparities based on geographic location	- The rule allowing for coverage for telemedicine services by CCOs is already in place and would just need to be updated. HSD would lead this, OHIT could play a consultative role. - Timing – this would be a contractual obligation starting with 2020 contracts, could decide to phase in (e.g., expectations that CCOs have coverage in their networks no later than end of year 1).	<u>Pros</u>: Better access to care, reduced barriers for telehealth options, more consistency across CCOs <u>Cons</u>: Some providers and patients lack the systems to engage in telemedicine consults through video. Some remote areas of Oregon lack high-speed broadband capabilities that would enable telehealth. <u>Feedback</u>: Multiple stakeholders expressed support for telehealth. Some input that the policy should be flexible to allow exceptions for services not clinically indicated for telehealth, and that quality of telehealth services should be monitored. Telehealth services are frequently needed when there are transportation barriers, or other SDOH related issues (e.g. poverty) creating a hardship for members to access services in person. BH services are especially suited for telehealth approach and used in Oregon in some rural areas. Concerns about patients needing a private setting when engaging with telehealth.					
			Fulfills state or federal mandate									
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New Policy Ideas: Year 1					
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29	CCOs, with the support of OHA, to require providers to implement trauma-informed care practices	Fulfills state or federal mandate	Improve health outcomes for all Oregonians	- Create OHA-wide trauma-informed approach policy - Internal OHA work group to direct trauma-informed approach within OHA to better support CCOs/providers - Work to sit in HSD and HPA	- HCR 33 <u>Pros</u>: Oregon is a national leader in trauma awareness and trauma-informed approach - Trauma Informed Oregon in full support of this policy - Legislation may be needed - Many CCOs are already implementing - Requires planful, thoughtful, coordinated response
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30	CCOs identify plans for the development of the medical, behavioral and oral health workforce including their efforts to: - Develop the health care workforce pipeline in their area; - Develop and support a diverse workforce who can provide culturally and linguistically appropriate care, with attention to marginalized populations - Ensure current workforce completes a cultural competency training in accordance with HB 2611 - Participate in and facilitate the current and future training for the health professional workforce in their area - Support health professionals following their initial training; and - Encourage local talent to return to their home areas to practice	★ Fulfills state or federal mandate	Increase workforce to ensure network adequacy; increase access and outcomes for Oregonians	- Health Care Workforce Committee will continue to contribute to the development of these efforts - HPA and HSD to monitor compliance	- HCWF, HEC and THW support; recommendation directly offered by HCWF; Dr. McKelvey contributed to the list to include in the plan. - Some CCOs have this in place now but not reviewed/supported by OHA; for others, asking for this will help them better think through questions of access. - Every state is required to develop a needs analysis as part of the PCO cooperative agreement. - Federally, HRSA requires states to maintain updated provider data. - HB 3261 requires a biennial needs assessment. - Need to consider whether “area” is only a CCO’s provider network or a geographic area served in part by the CCO.
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✓ Increases transparency					

New Policy Ideas: Years 2+					
#	Policy	Dashboard	Intended impact	Implementation	Considerations
31	Shift mental health residential benefit to CCOs	★ Fulfills state or federal mandate Priority area: BH How heavy is lift? ●●● How large is impact? ●●○ Equity TBD – OEI/HEC 2019 POP planned Requires legislation Potential to impact children ✓ May require OHA TA support ✓ Could have flexible timeline ✓ Increases transparency	Improve health care for adults with SPMI	- Supporting efforts (need for a workgroup, additional development, standing up of new reports, etc.) - Rate standardization is in process. Review of rates must be completed in one year and must precede transition of the benefit. - HSD resources (PM and analysts)	Required in 1115 waiver - Needs significant development - Kids residential and SUD have already transitioned to CCOs. MH res was scheduled in 2014 and a work group planned for transition, but was postponed due to complexity and CCO and provider concerns. - CareOregon supports
32	By year 2, CCOs required to implement three VBPs focused on key care delivery focus areas listed below. CCOs should select key care delivery areas that are most critical for their members in their service delivery areas. Required key care delivery focus areas are: - Behavioral health - Oral health - Hospitals - Children’s health care - Maternity care	Fulfills state or federal mandate Priority area: VBP How heavy is lift? ●●● How large is impact? ●●● Equity TBD – OEI/HEC 2019 POP planned Requires legislation ✓ Potential to impact children ✓ May require OHA TA support ✓ Could have flexible timeline Increases transparency	Uses VBP as a lever to advance OHA key care delivery goals	- CCOs will be required to add a key care delivery focus area each year so that they gain experience in each by the end of the 5-year contract. - OHA should encourage coordination and alignment by CCOs of VBP models in areas of overlapping CCO service areas.	- Flexibility of VBP models, design and size (i.e., no spend or population size requirement). - VBP models may combine care delivery focus areas. - Information gleaned may lead to more robust VBP requirements in one/more focus areas in future. - In the spirit of the global budget, not prescriptive in terms of dollars or % of members, but CCOs gain experience in key areas. - CCO 2.0 priority area; VBP can promote integration - Foundational to CCO model; VBP can promote integration - High-cost area could be addressed by VBP; minimal CCO VBP experience - Governor’s priority; widespread public support - Governor’s priority; major area of spending

Existing in contract; needs strengthening or improved monitoring												
#	Policy	Dashboard	Intended impact	Implementation	Considerations							
33	Continue CCO role in using HIT for patient engagement and link to health equity	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Patients better understand their health issues and treatment plans. Health disparities are addressed through targeted HIT-based programs that take into consideration member demographics, language, accessibility, and literacy.	• Timing – this would adjust current CCO contract requirements to align with the health equity plan process. • Accountability mechanism will relate to the health equity plan. This has been a component of the TQS in the past. • OHA TA could be useful. • OEI would lead and OHIT would play a consulting role, and would seek to support CCO efforts around HIT for patient engagement where possible.	• <u>Pro</u>: Better patient engagement and health outcomes • <u>Con</u>: Some providers lack the systems to engage with their patients electronically. Some systems may lack the ability to support needed language and accessibility modifications. • <u>Feedback</u>: Need support and guidance from OHA to help CCOs understand and leverage efforts in place (e.g., PCPCH requires patient portals), not sure how to incentivize members to use HIT. Some patients have multiple patient portals – which can be onerous and confusing. Patient control of their own health information is important – including the ability to correct information.					
			Fulfills state or federal mandate									
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34	Increase CCO accountability to sustainable growth target by adding accountability and enforcement provisions to CCO contracts Connect contractual requirements to ongoing evaluation of Oregon’s sustainable spending target based on national trends and emerging data to inform more aggressive targets in future while providing CCOs with additional financial incentives to achieve spending targets in the form of shared savings arrangements	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	CCOs are held accountable for achieving spending growth targets and targets reflect aggressive path to ensure costs grow at a sustainable rate	• Include a contract requirement with enforcement options requiring CCOs to achieve current and future sustainable rate of growth targets • RFA language will clarify spending targets set by waiver and legislature are a CCO deliverable • OHA process developed to evaluate current spending targets and inform spending target(s) in future waiver renewals	• OHA has achieved program-wide spending targets in the first five years • Connects OHA’s waiver commitment to CCO contracts • OHA may choose to allow CCOs to meet the target over a rolling period (i.e., 3 years, etc.) • Shared savings arrangement provides clarity to CCOs that program-wide savings will be reinvested into program ○ Similar to initial funding build-up of quality pool					
			Fulfills state or federal mandate									
		<table><tr><td>Priority area:</td><td>COST</td></tr></table>	Priority area:	COST								
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35	Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy (AZ Model) with financial implications	★ Fulfills federal regulatory req. Priority area: COST How heavy is lift? How large is impact? Equity TBD – OEI/HEC 2019 POP planned Requires legislation Potential to impact children ✓ May require OHA TA support ✓ Could have flexible timeline ✓ Increases transparency	Encounter data accurately reflects health care services provided to OHP enrollees	- Implementation planned for 2020 contracts utilizing new resources added to the Program Integrity Provider Audit Unit from 17-19 POP - Five of seven auditors funded in POP have already been added	- Intended to fulfil CMS requirements to ensure that encounter data is “complete and accurate” and to ensure it reflects services provided to patients - Capacity being added to provider audit unit related to prior POP - Alternative ways to meet federal requirements necessary without this option
36	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), and incorporate the following: - Develop standards for care coordination - Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD) - Establish outcome measure tool for care coordination	Fulfills state or federal mandate Priority area: BH How heavy is lift? How large is impact? Equity TBD – OEI/HEC 2019 POP planned Requires legislation ✓ Potential to impact children ✓ May require OHA TA support Could have flexible timeline Increases transparency	Increase access to behavioral health services, allow members provider choice. Improve health outcomes. Ensure care coordination is efficient and impactful for the highest risk members.	- OHA to develop standards and outcomes measure. - Work would live within HSD. HPA Analytics would be involved for outcome measure.	- Feedback we received indicated there are multiple care coordinators assigned and that there needs to be coordination or role clarification. - Oregon Center for Children and Youth with Special Health Needs supports with a call out for those transitioning from pediatric to adult systems; Trillium supports with call out for families; Children's Health Alliance and Oregon Center for Children and Youth with Special Health Needs supports developing standards; Children's Health Alliance supports for care coordination for child welfare and other prioritized populations.

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37	Develop mechanism to assess adequate capacity of services across the continuum of care. Ensure members have access to services across the continuum of care.	<table><tr><td>★</td><td>Fulfills state or federal mandate</td></tr></table>	★	Fulfills state or federal mandate	Provide a full continuum of behavioral health, medical and oral health services throughout the state. Ensure members have access to a provider network. Will improve health outcomes.	- Need to develop or adopt mechanism. OHA to define continuum of care and network adequacy. - Would sit in HSD.	- This is in current contract but has not been enforced. - Likely our understanding of “adequate capacity” will expand and evolve from what it was understood to be in CCO 1.0. Fulfills a federal requirement to identify mental health shortages. - Further development needed, especially around compliance.										
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38	System of Care to be fully implemented for the children’s system	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Improve health outcomes for children through a system of care	- Hold CCOs accountable to full implementation of existing model to ensure cross system collaboration. - Statewide Systems of Care (SOC) Steering Committee empowerment: State agencies (OYA/OHA/DHS/ODE) to fund the State System of Care steering committee with existing general fund from each child serving state agency for multi-agency needs and development of shared services and supports. - Clarify with CCOs and communities the advisory council roles and responsibilities as they relate to the broader System of Care governance structure.	- The already-existing System of Care (SOC) governance infrastructure was launched in 2014 and continues to mature and develop. OHA contractually requires CCOs to have local SOC structures in place and these have been developed and maintained with consultation from PSU System of Care Institute. The institute is funded jointly, through an interagency agreement between DHS – Child Welfare, OHA and PSU. - Pros: SOC is already established, needs fine tuning for some CCOs/areas. - Cons: Difficulty getting system partners to the table, lack of blended funding hampers efforts. - Much national research exists documenting cost savings. - HB2144 Youth Wraparound Initiative names system partners. - This will reflect values and principles to the local governance structure.										
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39	Require Wraparound is available to all children and young adults who meet criteria	★ Fulfills state or federal mandate	Improve health outcomes for children	Require CCOs to meet national average for fidelity implementation per WFI-EZ scores (fidelity tool/consumer survey) Enforcement of existing contractual expectations will be critical to success Work would sit in HSD	This was in the CCO contract but not enforced. Enforcement will be critical to success. <u>Pros</u>: Wraparound is documented to improve outcomes for children and families; long-term cost savings, and improvement in health outcomes for families. HB2144
		Priority area: BH			
		How heavy is lift?			
		How large is impact?			
		Equity TBD – OEI/HEC			
		2019 POP planned			
		Requires legislation			
		✓ Potential to impact children			
		May require OHA TA support			
		Could have flexible timeline			
Increases transparency					
40	MOU between CMHP and CCOs enforced and honored	Fulfills state or federal mandate	Improved health outcomes and increased access to services through coordination of safety net services and CCO Medicaid services	Enforcement would sit in HSD	The CCOs have the MOUs but not all have been fully implemented Would result in coordination of safety net services in each region Supported by AOCMHP
		Priority area: BH			
		How heavy is lift?			
		How large is impact?			
		Equity TBD – OEI/HEC			
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41	Require CCOs support EHR adoption across behavioral, oral and physical health contracted providers	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Behavioral and oral health providers adopt and use EHRs more effectively and at higher rates, allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements.	- Timing – This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers. - We would expect CCOs to evaluate current EHR adoption rates and opportunities, set targets and report on progress – phased over 5 years. - OHA TA could be useful. - Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO needs for data on EHR adoption where possible.	<u>Consideration</u>: CCOs’ primary care providers successfully increased EHR adoption, with federal incentive payments. This policy option would build on that success. This will be most helpful if BH EHR Incentives (POP requested) are available as well. <u>Pro</u>: Encouraging and supporting the adoption of EHRs capable of information exchange and connecting to health information exchange tools and services would support increased care coordination and improve patient care. <u>Con</u>: Providers may lack resources to invest in EHRs or lack staff capacity to implement workflow changes needed for effective use of EHRs. <u>Feedback</u>: CCOs may face significant challenges to this if resources/incentives are not available.											
			Fulfills state or federal mandate															
		<table><tr><td>Priority area:</td><td>BH/HIT</td></tr></table>	Priority area:	BH/HIT														
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42	Require CCOs ensure behavioral, oral and physical health contracted providers have access to health information exchange technology that enables sharing patient information for care coordination, including timely hospital event notifications, and require CCOs use hospital event notifications	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Behavioral, oral and physical health providers have the information needed to deliver better care, patients get the right care at the right time, and costly hospital use is reduced	- Timing – This would be a contractual obligation starting with 2020 contracts, that adjusts current CCO contracts to specify BH, oral and physical providers. - We would expect CCOs to evaluate current HIE use and opportunities, set targets and report on progress – phased over 5 years. - OHA TA could be useful. OHA is currently supporting TA for hospital event notifications related to the CCO Disparity metric. - Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIE where possible.	<u>Consideration</u>: OHA currently financially supports PreManage directly for CCOs on a voluntary basis (all CCOs are now using PreManage either directly or through regional HIE), and nearly all CCOs are paying to extend PreManage to their key clinics, including BH, oral, physical. When PreManage subscription ends through the state for CCOs (end of 2019), CCOs have the option to continue with the PreManage tool at their own cost. - OHA is launching the HIE Onboarding program that will support initial costs to connect key clinics (including BH, oral, physical) to approved HIEs (only one is approved at this time). <u>Pro</u>: Reduction in ED utilization. Increased health outcomes for members with complex care needs and mental illness. Increased care coordination between CCO and contracted clinics <u>Con</u>: Providers may lack resources to participate in HIE or lack staff capacity to implement workflow changes needed <u>Feedback</u>: Interest in sharing costs or leveraging OHA financial support to help CCOs in this area, OHA can support education/TA for HIE and for SUD info sharing policies, concerns about this requirement going beyond adoption of PreManage and requiring CCOs to support multiple HIE platforms, which would have less utility for providers.											
			Fulfills state or federal mandate															
		<table><tr><td>Priority area:</td><td>BH/HIT</td></tr></table>	Priority area:	BH/HIT														
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			2019 POP planned															
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Existing in contract; needs strengthening or improved monitoring																	
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					Consideration of all partners that need to be in HIE including families, caregivers, SDOH entities, jails, etc.												
43	Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting, including to risk stratify populations and manage population health efforts, manage VBP arrangements with contracted providers, and manage VBP data. This would include a demonstration that the CCO can work with electronic clinical quality measure data.	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	CCOs are better able to achieve population health outcomes at lower costs. Providers engaging in VBP contracts have the information and support needed from the CCO to manage financial risk and improve care.	- CCOs would be encouraged to take advantage of collaborative efforts related to data aggregation, eQMs, and other VBP data needs. In their RFA response, CCOs would show they meet an initial minimum and explain how, during the first year of the contract, they will ensure they have sufficient HIT capabilities for VBP and population health management. - Accountability mechanisms TBD – this has been a component of the TQS. OHIT would play a consulting role, and would seek to support CCO efforts around HIT where possible. - OHA should consider TA/ support for CCOs in this area – possibly through Transformation Center/TA Bank and/or OHIT.	<u>Pro</u>: Without data and HIT systems, CCOs cannot deliver on VBP. If we expect CCOs to become more sophisticated around VBP in 2.0, they must have the skills and systems to do so. Ability to use clinical data/metrics is critical to moving toward triple aim. <u>Con</u>: CCOs face challenges in getting and using clinical data – may need HIE strategy to help with this. Some providers may lack the capability to use CCO data effectively. Possible proliferation of systems across CCOs and payers. <u>Feedback</u>: Multiple stakeholders expressed support for this – very important for moving into the future. This will be a heavy lift for some of our current CCOs, including obtaining clinical data. Some CCOs will likely need TA and support.										
			Fulfills state or federal mandate														
		<table><tr><td>Priority area:</td><td>VBP/HIT</td></tr></table>	Priority area:	VBP/HIT													
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Recommendations to/for OHA																	
#	Policy	Dashboard	Intended impact	Implementation	Considerations												
44	Establish a more robust team in OHA responsible for monitoring, compliance and enforcement of CCO contracts, building on existing resources.	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Streamline and enhance OHA’s capacity for contract management and compliance Increase understanding of CCO effectiveness and provide improved support to CCOs over contract issues	TBD – would require assessment of current resources and possible reallocation of existing capacity and/or new capacity.	- In addition to monitoring, tracking, and ensuring compliance with CCO 2.0 policies, this team would be tasked with oversight of policy options 34–45 above, which have already existed in contract but have not been achieved as intended. - Enhancing compliance around CCO contracts is a natural next step from CCO 1.0 – during the first contract, CCOs were building new businesses and the priority was around ensuring the model was successful. CCO 2.0 provides an opportunity to increase accountability around actual contractual obligations										
			Fulfills state or federal mandate														
		<table><tr><td>Priority area:</td><td>ALL</td></tr></table>	Priority area:	ALL													
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45	Support providers in utilizing ACEs score, and/or trauma screening tools to develop individual service and support plans. Additional tools used shall be outcome based and reflective of best/emerging practices.	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Creation of a trauma-informed health care system	Formation of OHA-wide work group to advise on trauma-informed approaches and tools; separate linked work group to examine best/emerging practices	- HCR 33 from 2018 session - Trauma Informed Oregon supports use of trauma-informed approach across OHA and by CCOs - Legislation needed: Other states are passing this type of legislation (to address trauma-informed services) - Trauma-informed approaches must be a foundation on which other services are conducted - Recommendation in the OHA-DHS Continuum of Care proposal that state agencies pursue trauma-informed approaches										
			Fulfills state or federal mandate														
		<table><tr><td>Priority area:</td><td>BH</td></tr></table>	Priority area:	BH													
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Recommendations to/for OHA					
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46	Identify and address billing system and policy barriers that prevent behavioral health providers from billing from a physical health setting	Fulfills state or federal mandate	Increase integration, increase access, expand provider network	- Will require HSD Medicaid staff to complete this work. The position is currently vacant. - Work to be completed in HSD.	- Work groups have submitted recommendations to OHA. - This will allow providers to bill from integrated settings. - Will increase access and expand the provider network.
		Priority area: BH			
		How heavy is lift?			
		How large is impact?			
		Equity TBD – OEI/HEC			
		2019 POP planned			
		Requires legislation			
		✓ Potential to impact children			
		May require OHA TA support			
		Could have flexible timeline			
Increases transparency					
47	Develop payment methodologies to reimburse for warm handoffs, impromptu consultations and integrated care management services	Fulfills state or federal mandate	Increase integration, access and provider choice by eliminating billing barriers	- Work groups have submitted recommendations, which will be operationalized by HSD. - Work to be completed in HSD with technical assistance through the Transformation Center.	- Will take HSD Medicaid staff to complete. The position is currently vacant. - Payment methodologies will allow for provision on full continuum of behavioral health services. - Oregon Academy of Family Physicians supports all BH in integrated PC be reimbursed; Children's Health Alliance supports BH to be billable in PC for all services provided and should be seamless to provider and patient; Oregon Medical Association supports reimbursement rates to support integration.
		Priority area: BH			
		How heavy is lift?			
		How large is impact?			
		Equity TBD – OEI/HEC			
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#	Policy	Dashboard	Intended impact	Implementation	Considerations
48	Examine equality in behavioral health and physical health reimbursement	Fulfills state or federal mandate	Increase integration by equalizing the reimbursement gap between BH and PH	- Requires additional development – what exactly would CCOs be required to do as part of this examination. - Work would sit in HSD Medicaid.	- Position that would complete this work in HSD is vacant. - Oregon Academy of Family Physicians supports all BH in integrated PC be reimbursed; Children's Health Alliance supports BH to be billable in PC for all services provided and should be seamless to provider and patient; Oregon Medical Association supports reimbursement rates to support integration.
		Priority area: BH			
		How heavy is lift?			
		How large is impact?			
		Equity TBD – OEI/HEC			
		2019 POP planned			
49	Develop an incentive program to support behavioral health providers’ investments in electronic health records and other, related HIT. (Feasibility depends on 2019 legislative session)	Fulfills state or federal mandate	If OHA is able to implement an incentive program, the result would be BH providers have better EHRs allowing them to better participate in care coordination, contribute clinical data for population health efforts, and engage in value-based payment arrangements. CCO participation in prioritizing BH providers for these incentives helps ensure the funding is targeted well and achieves the desired impact for our Medicaid population.	- Timing: Following 2019 legislative session – if OHA is successful in getting POP/funding approved. - Likely process would include leveraging CCO input through an existing work group (CCO HIT Advisory Group – [HITAG]) on development and oversight of the incentive program, as well as a CCO engagement process to identify high priority BH providers. Ideally we would make incentives available in early-mid 2020. - OHIT would staff this program and the CCO HITAG/CCO engagement.	<u>Pro</u>: BH Providers are incentivized to improve their HIT to support integration and care coordination. CCO involvement is needed to ensure OHA understands local community needs when making decisions about priority providers; incentive dollars make a bigger impact.<u>Con</u>: Providers may lack staff capacity to implement workflow changes needed for effective use of EHRs. Technical assistance may be needed and support from CCOs or OHA to be effective. <u>Feedback</u>: Strong support among BH providers for incentive program, which would help close the “digital divide” that behavioral health providers face. These providers have been largely left out of federally funded programs that support EHR adoption and use.
		Priority area: HIT			
		How heavy is lift? or			
		How large is impact?			
		Equity TBD – OEI/HEC			
		✓ 2019 POP planned			
		Requires legislation			
		Potential to impact children			
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Not recommended at this time												
#	Policy	Dashboard	Intended impact	Implementation	Considerations							
50	Expand/revise existing risk corridor programs This option is not being recommended as a result of recommendation to examine in greater detail the idea of establishing a program-wide reinsurance program	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Additional use of risk corridors not a formal component of recommendations	No new proposals for risk corridors	Risk corridors remain a tool at OHA’s discretion in the next 5-year contract period.					
			Fulfills state or federal mandate									
		<table><tr><td>Priority area:</td><td>COST</td></tr></table>	Priority area:	COST								
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51	Incentivize health care services with highest clinical value by rewarding their use in rate setting This option has been incorporated as aspect of variable profit implementation strategy	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	CCOs focus additional energy on moving providers to deliver health care services with higher clinical value and reduce provision of low-value care	• Phased-in approach preferred • Formal work group (possibly a HERC subcommittee?) needed to evaluate services for placement on a high or low-value list. • Clinical-value could be used as part of methodology informing CCO-specific variable profit levels	• Policy option can be viewed as a next step for Oregon’s prioritized list to further shift the system to providing evidence based, high-value services to patients (Benefits 2.0). • Phasing in the development of a high and low value list could ease concerns from CCOs about pushing too hard too fast. • OHA could strategically choose to include this program in legislation for the upcoming session.					
			Fulfills state or federal mandate									
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52	Development of a Train the Trainer investment in BH models of care	<table><tr><td></td><td>Fulfills state or federal mandate</td></tr></table>		Fulfills state or federal mandate	Increase in BH providers trained in evidence-based	• Formation of a Statewide Train the Trainer Model and/or Training Initiative (less	Would require funding and position authority. May be considered for a future POP.					
			Fulfills state or federal mandate									

Not recommended at this time

#	Policy	Dashboard	Intended impact	Implementation	Considerations																				
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