



CCO Community Advisory Council Meeting

UO Riverfront Research Park
1800 Millrace Drive
Eugene, Oregon 97403

Monday, June 25, 2018

12:00 - 2:00 pm

Oregon Research Institute Bldg., 2nd Floor,

Minutes

Attended: Tara DaVee, Caitlynn Hatteras, Dawn Helwig, Richard Kincade, Marianne Malott, Silverio Mogart, , John Radich, Char Reavis, Cindy Shirtcliff, Carla Tazumal
Tele Conference: Lauren Dionne (Trillium), Cindy Kallstrom (OHA), John Rolling Thunder
Recorder: Jan Skeie, LCPH/Prevention

Guests: Debi Farr - Trillium
Lucy Zammarelli – Trillium
T.K. Wuest, Trillium
Tina Potter – Trillium
Chris Eiler, Trillium
Robert Stalbow, Cardiac Rehab, Sacred Heart / PeaceHealth
Robert Drake Eubanks, Lane Consumer Council
Margaret Gonzales, Lane Consumer Council
Jennifer Webster, Sr. CHA, Lane County Prevention Program
Jacqueline Moreno, CHA2, Lane County Prevention Program

Absent: Val Haynes, Roxie Mayfield, Heather Murphy, Susanna Sammis, Jocelyn Warren, David Young

1. **Call Meeting to Order** – Meeting opened by Caitlynn Hatteras, Co-Chair.
2. **Public Comment:** No public comment.
3. **Introductions and Welcome –Caitlynn Hatteras – Co-Chair.** Staff introductions.
4. **Approve Minutes** – Rick Kincade moved to approve the April meeting minutes and Cindy Shirtcliff seconded the motion. Motion to approve passed to accept the minutes as written.
5. **Reports**
 - a. **Trillium Report** –Report by Debi Farr and Lucy Zammarelli.
 - **Provider Diversity Survey** – We have received half of the surveys back from providers.
 - **Produce Plus Program** – We are partnering with Food for Lane County to expand the Produce Plus Program and improve health through a new pilot project that will integrate free access to fresh produce with diabetes prevention education.
 - **2018 CCO Incentive Measure Benchmarks Report** –We received our metrics report from the Metrics and Scoring Committee. We met 14 out of the 17 Metrics to meet the challenge pool, which is very high.
 - b. **CAP Report** – Report by Rick Kincade.

- The Clinical Advisory Panel (CAP) is focusing on no-shows. Recommendations were made to the Board.
- Patient Education – making sure everyone has the right numbers.
- Decreasing barriers to get patients in for same day services.
- Looking at integrated services between behavior health, primary care, and dental services.
- Improving access to housing and food.
- Reviewed CCO metrics for 2017 and YTD 2018.

c. **RAC Report** – Report by Char Reavis.

- RAC met in Oakridge. The meeting was well attended. Several people were interested in serving on the RAC. Main problems for Oakridge clients were:
 - same day transportation;
 - not enough mental health services.

6. **“No Show” Recommendations**

(See attached Addressing No Shows: Some Recommendations and Bridges Out of Poverty Model)

Tara, Caitlynn, Cindy, and Leah presented the No Show Recommendations to the Trillium Governing Board. These recommendations were based on the Bridges Out of Poverty Model.

The members recommended that the following should be included:

- Scheduling changes:
 - Reduce waiting times
 - Open scheduling
 - Easier mechanism for cancelling and education on procedure
 - More reminders and using multiple styles
 - Education about clinic processes and procedures
- Creating a welcoming practice
 - Increase cultural agility
 - Reduce linguistic barriers
 - Health literacy practices
 - Welcoming spaces
- Incentives

7. **CCO 2.0 Presentation**

Report by Veronica T. Guerra from Health Net and Debi Farr, Trillium

(See attached 2.0 Presentation). The CCO 2.0 Celebration will be June 26, 2018 at 6 pm at the Holiday Inn at Gateway in Springfield. (see attached invitation).

No meeting in July

Next meeting: Monday, July 27, 2018; 12 – 2pm, Oregon Research Institute Bldg., Second Floor. We will be having a check-in and party.

Adjourned.

Addressing No Shows: Some Recommendations

Presented by:

The Trillium Community Advisory Council and Rural Advisory Council

Our Approach:

Our recommendations are based on three sources of information.

1. Focus group findings: Members of the Trillium CAC and RAC participated in a focus group to identify the challenges Trillium members experience that lead to missed appointments.
2. Academic literature review: Citations provided.
3. Survey analysis: We analyzed responses from 156 Trillium members who were surveyed in local DHS offices.

The No Show Population – Who are they?

According to the literature, patients who are low-income, on Medicaid, in single-parent household, are people of color, people with a serious behavioral health diagnosis and/or are male are more likely to not show for an appointment. What we know about Lane County seems to bear out the same trends.

The Barriers – Why don't they come?

1. Transportation – unreliable personal transportation, lack of same day transportation assistance, lack of public transportation, scheduling, etc.
2. Cultural disconnects- linguistic and cultural challenges, lack of understanding regarding the health system, poverty perspective vs middle class perspective.
3. Work and childcare scheduling- minimum wage jobs generally don't allow for time off and schedules are inconsistent, childcare is often informal and unreliable.

4. Mental health – anxiety, addiction, fear of bad news fear of being judged/embarrassed, of not understanding, fear of consequences beyond the clinic (i.e. having children removed or immigration issues.)
5. Lack of understanding- regarding how the system works, the impact of missing an appointment vs cancelling, of preventive care, of their own benefits.
6. Health Literacy- communications with the clinic not clear or not in the language needed, directions too complicated or at too high a reading level.

Recommendations- What changes are most likely to reduce the no show rate?

Appointments:

How appointments are made and managed have a huge impact on whether a patient shows up or not.

1. Scheduling:
 - a. Reduce wait times- appointments made within 30 days of the request are half as likely to result in a no show as those with a longer lead time.
 - b. Open scheduling- appointments that are walk-in, open regardless of urgency, and flexible.
 - c. Make canceling easier- by text, email, dedicated line. Patients often don't want to talk to anyone, also are not likely to wait on line or jump through lots of hoops.
2. Reminders:
 - a. Timing- 3-5 reminders, one week before, 48 hours before and the day of the appointment.
 - b. Type of message:
 - i. Verbal human contact with the patients 48 hours before the appointment played a significant role in the reduction of patient non-attendance.

- ii. Utilizing different modalities (text, email, voicemail, verbal contact, postcard, automated/staff) increases the likelihood of patient getting the message.
- c. Content should:
 - i. Be in patient's primary language.
 - ii. Be easy to understand, in "layman's terms", at 5th grade comprehension level.
 - iii. Be non-judgmental, friendly.
 - iv. Have clear instructions for accepting and for cancelling.
 - v. Focus on relationship building.
 - vi. Educate about healthcare and the healthcare system.

Relationship Building:

Patients who feel comfortable, valued and connected to their primary care practice are more likely to show up or re-schedule, and are more likely to follow through with recommendations.

1. Create a welcoming practice
 - a. Train staff, including front desk and schedulers, regarding cultural competency and socioeconomic sensitivity.
 - b. Reduce linguistic barriers by hiring bilingual/bicultural staff, including front desk and schedulers.
 - c. Perform a health literacy audit.
 - d. Create a comfortable, family friendly space.
 - e. Create waiting rooms and exam rooms that comfortably accommodate patients with disabilities and ensure equal access to care.
2. Incentives - Providing an incentive can increase the likelihood a patient will show or re-schedule.
 - a. Gift cards – as small as \$5.00 can be effective.
 - b. Gift drawings – patient receives an entry for a larger prize such as an iPad, \$100 Fred Meyer card, etc.

- c. Freebies- branded products like water bottles, first aid kits, etc., build good feeling for the practice.
- d. Basic goods- food, transportation vouchers, clothes, etc. (can partner with local agencies like Food for Lane County).

References:

Drewek, Rupali, et al. "Lead Time to Appointment and No-Show Rates for New and Follow-up Patients in an Ambulatory Clinic." The Health Care Manager, vol. 36, no. 1, 2017, pp. 4–9.,

Huang, Yu-Li and Sarah Bach. "Appointment Lead Time Policy Development to Improve Patient Access to Care." Applied Clinical Informatics 7:954-968, 2016

Miller, Anya J, et al. "Predictors of Repeated 'No-Showing' to Clinic Appointments." Egyptian Journal of Medical Human Genetics, Elsevier, 30 Jan. 2015

Shimotsu, Scott, et al. "Increased Likelihood of Missed Appointments ('No Shows') for Racial/Ethnic Minorities in a Safety Net Health System." Journal of the American Dietetic Association, Elsevier USA, 1 Jan. 2016

Simmons, Derek, and Joanna Jarman-McCabe. "Implementing Clinic Information Pamphlets to Reduce New Patient No-Show Rates." Pilot Scholars, 2016

Vijayan, Maalinii. "No Shows: Effectiveness of Termination Policy and Review of Best Practices." CORE Scholar, 2014

Williams, Sherry, et al. "How Come They Don't Come? Identifying Reasons of Non-Show Among a Palliative Care Outpatient Clinic." Palliative Care Definition, 2016



Integration, Innovation, Transformation

CELEBRATING 5 YEARS OF COORDINATED CARE IN LANE COUNTY



Celebrating 5 Years as a Coordinated Care Organization Serving Lane and Western Douglas County's Oregon Health Plan Members

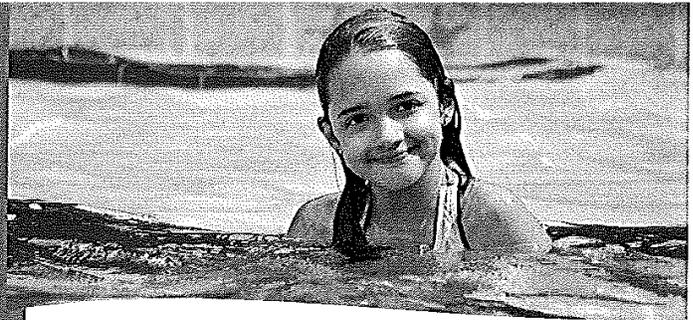
The first five years for Oregon Coordinated Care Organizations have confirmed the benefits of the state's vision of serving our most vulnerable residents most effectively. By better coordinating all elements of their care at the local community level, Trillium and Lane County have become recognized leaders for their partnership and successful integration of behavioral health and primary care.

We are thankful for all of our providers and community partners who helped make the first five years a success. We remain accountable and steadfast in our commitment to improving the health of our community by working to achieve our shared goals of reduced health disparities and better care at lower costs.

Chris Ellertson
CEO, Trillium Community Health Plan

Karen Goffney
Director, Lane County Health & Human Services
Vice Chair, Trillium Governing Board

Mark Aloysius, MD
Managing Partner, Springfield Family Physicians
Chair, Trillium Governing Board



Community Collaboration

Since our launch as a Coordinated Care Organization (CCO) in August 2012, Trillium Community Health Plan has partnered with Lane County Health & Human Services and the provider community to extend comprehensive, patient-centered care to Oregon Health Plan (OHP) members focused on prevention, health equity and delivering high quality care. We believe shared accountability and collaboration are critical to successfully improving the health of our community.

All health care is local. Our partnership ensures that we go beyond state requirements to address the unique needs of our communities. We accomplish that by involving community members in our governing board and through our two community advisory councils that represent the metro and rural areas of Lane and Western Douglas counties.

"In 2015 Trillium brought a mobile vision van to Florence and Peedport to provide vision exams and glasses to adults who weren't eligible for this benefit through the Oregon Health Plan. Many people in my community received glasses and are able to perform better at their jobs or read to their children or grandchildren thanks to that access."

Char Reavis, Chair, Trillium Rural Advisory Council



Live Healthy Lane: Working together to create a caring community where all people can live a healthier life. In 2013, Trillium collaborated with Lane County, PeaceHealth and United Way to conduct a community health needs assessment to determine the most significant health needs of our community.

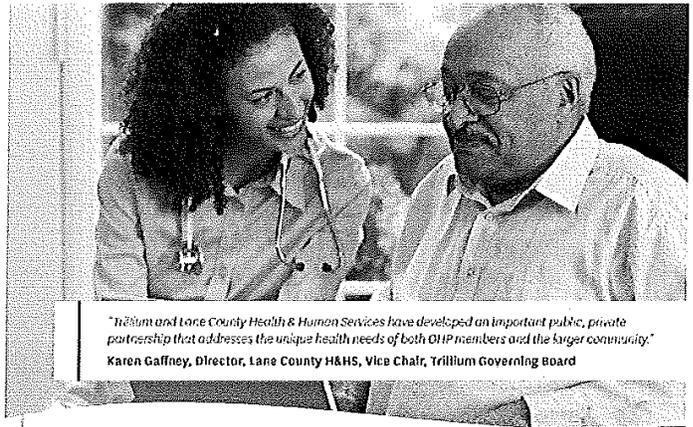
The partnership developed a Community Health Improvement Plan (CHIP) that provides the framework to collaboratively improve community health. Every three years, community needs are reassessed and the plan is updated.



CHIP 1.0 2013-2016 ACCOMPLISHMENTS INCLUDE:

- Improved collaboration across sectors.
- Increased awareness of the social determinants of health and other community health issues.
- For overall health outcomes, Lane County improved in ranking from 17th out of 36 Oregon counties in 2013 to 12th in 2016.
- Established the Lane Equity Coalition aimed at building and sustaining a community wide effort to increase equity by identifying and reducing health-related disparities.
- Increased public and leadership understanding and support of effective tobacco prevention.
- Built community leaders' and decision makers' understanding of a public health approach to obesity prevention, the history of obesity prevention efforts in Lane County and across the nation, and the history of obesity prevention strategies.
- Improved access to mental health care and increased the integration of behavioral health into primary care.

What's next? **CHIP 2.0 2016-2019** is focused on increasing economic and social opportunities that both promote and increase healthy behaviors to improve health and well-being.



"Trillium and Lane County Health & Human Services have developed an important public, private partnership that addresses the unique health needs of both CHIP members and the larger community."
Karen Gaffney, Director, Lane County H&HS, Vice Chair, Trillium Governing Board



Integration

BEHAVIORAL HEALTH

When the CCO launched, Lane County co-located its LaneCare work force within Trillium and became known as Trillium Behavioral Health. The result was an innovative model of shared accountability delivering physical and behavioral health services to better treat the whole person that has become a shining example of a successful public, private partnership.

In 2013, the **Trillium Integration Incubator Project (TIIP)** was created through grant funding to integrate behavioral healthcare in four primary care clinics and primary care into four behavioral health clinics. Integrating behavioral and physical health care eases provider/patient engagement and allows the clinicians to work together on unified care plans. Members are reporting higher satisfaction and TIIP has become the new model of care in our community.

"Thanks to Trillium's investment, Willamette Family's Health clinic has been better able to provide services to a part of our population that wasn't visiting their primary care providers and, instead, were frequenting the emergency room for care. By co-locating our health clinic in the same building as our Rapid Access Center, patients could receive immediate access to integrated behavioral health care and primary care."

Susie Dey, Executive Director, Willamette Family, Inc.

ORAL HEALTH

In April 2014, Trillium further advanced integration by contracting with the four Dental Care Organizations in Lane County, providing enhanced access to oral health services to OHP members. To encourage access, Trillium created easier identification of dental providers, making it less burdensome for OHP members to receive services.

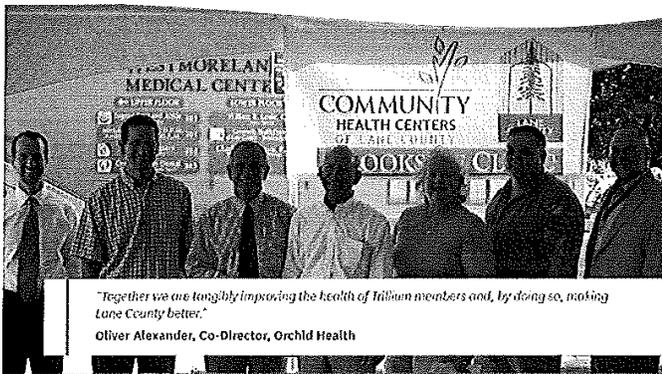
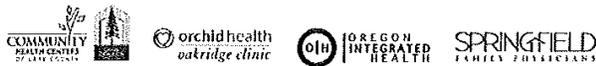
TRANSPORTATION

In 2014, Trillium initiated a contract with LTD/Ridesource for member transportation benefits that includes mileage reimbursement, bus passes, taxis/cabs and wheelchair or stretcher vans.

ACCESS AND ACCOUNTABILITY: RESPONDING TO RAPID GROWTH

In 2014 and 2015 Medical expansion caused Trillium OHP membership to nearly double in size. The rapid growth in membership meant more primary care providers were needed in Lane County. To resolve the provider shortage challenge as quickly as possible and in response member access to care, Trillium offered additional payments to providers for accepting new OHP patients, provided consulting services to improve work flow, and awarded grants to increase space in existing clinics so they could accept additional patients.

Trillium also provided funding to help open five new primary care clinics:



"Together we are tangibly improving the health of Trillium members and, by doing so, making Lane County better."

Oliver Alexander, Co-Director, Orchid Health



Innovation

In addition to integrated care, collaborative efforts with Lane County Health & Human Services have focused on creating population-based programs to address tobacco use and obesity in low-income communities.

As a PCO, Trillium has invested a fixed monthly amount per member in prevention strategies. This dedicated investment has generated nearly \$1 million each year to fund Lane County staff positions, including a prevention specialist, epidemiologist and education program coordinator. The funding also pays for prevention programs, including:

The Good Behavior Game – A classroom management tool that has shown to reduce tobacco use by up to 50%.

A Coordinated Approach to Child Health – Encouraging children to identify healthy foods, and increase the amount of moderate to vigorous physical activity they engage in each day.

Triple P – An online parenting tool designed to help parents confidently manage their children's behavior.

Community-Based Parenting Education – A parenting series that teaches parents how to set and stick to reasonable limits, listen to their children and understand their feelings, and deal with the day-to-day stresses of parenting.

Quit Tobacco in Pregnancy (QTIP) – An incentive program that helps women quit using tobacco during and after their pregnancy.

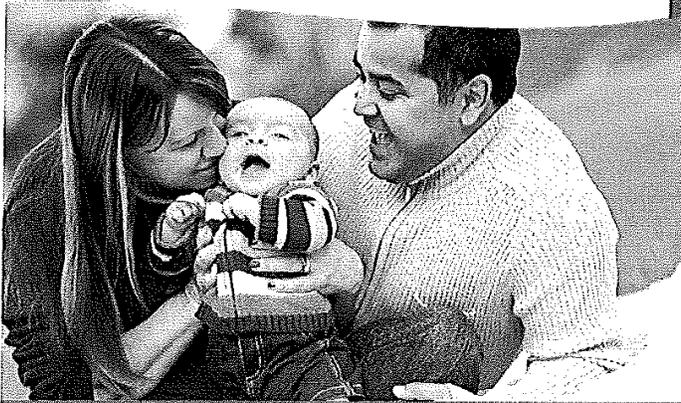
Double Up Food Bucks – Encourages healthy eating by matching up to 40% of Supplemental Nutrition Assistance Program (SNAP) coupons (\$20 per day) toward the purchase of fresh produce at participating Farmers Markets.

Trillium community partnerships also address innovative solutions to health disparities and critical social determinants of health. Examples include:

The Nuestras Familias (Our Family)—project establishes a culturally specific and responsive wrap-around program for Spanish-speaking Latino families. The wrap-around program is a team-based planning process involving members 0-17 years of age and the member's family that results in unique community services and support for the member and family.

The Cornerstone Community Housing Healthy Homes Program—goals are to assist Trillium OHP members in navigating and engaging in the healthcare system, increasing their trust in healthcare providers, and encouraging engagement in preventive care and wellness activities. Cornerstone Community Housing provides supported affordable housing to 1,125 residents of whom approximately 6,400 are Trillium OHP members living at seven of Cornerstone's nine Eugene-Springfield area locations. Cornerstone provides and coordinates programs to increase the health and well-being of its residents.

The Medical Recuperation Program—a collaboration between Trillium, Sheltercare and PeaceHealth Trillium case managers identify homeless members in the hospital who have a medical need that requires stable housing. They work with social workers at RiverBend hospital to prepare for a warm hand-off to Sheltercare at discharge. During their 30-day respite these members are assisted by Community Health Workers to meet their medical care regimen by encouragement and support to participate in needed care. These workers also assist in identifying potential permanent housing. Early results show ER visits and hospital readmissions have decreased.



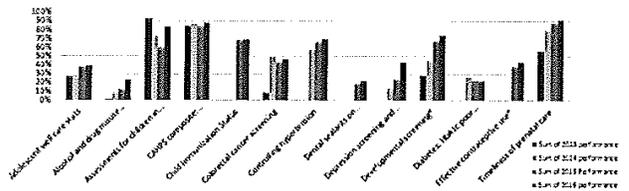
Quality

Earning incentive metric quality pool funds has required collaborative efforts by Trillium and our provider partners. Quality funds are held in reserve by the state. CCOs earn them back by meeting either the benchmark or annual improvement target assigned to each measure. Trillium shares 92% of its incentive payments with the provider community as quality bonus payments.

In 2016 Trillium was in the top quartile of all 16 CCOs for the following measures:

- Assessments for children entering foster care (4th place, improved 23.2% over 2015, overall rate 83.3%)
- Controlling high blood pressure (2nd place, overall rate 69.7%)
- Screening to determine mental and physical development of children 0-3 years of age (2nd place, overall rate 73.6%)
- Diabetes care (1st place, overall rate 92.2%, lower is better)
- Member satisfaction with healthcare providers (2nd place, overall rate 88.3%)

TRILLIUM PERFORMANCE METRICS IMPROVEMENT YEAR-OVER-YEAR





"Our collaborative efforts on quality improvement have resulted in better health maintenance, better disease management and early detection, and ultimately, an improved quality of life for Trillium members."

Thomas K. Wuest, MD, Chief Medical Officer, Trillium Community Health Plan



TRILLIUM COMMUNITY HEALTH PLAN IS AN ACCREDITED NCOA MEDICAID HEALTH PLAN. TRILLIUM COMMUNITY HEALTH PLAN IS CURRENTLY THE FIRST AND ONLY MEDICAID CCO IN OREGON TO RECEIVE THIS DESIGNATION.

The National Committee for Quality Assurance (NCQA) is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of health care organizations and recognizes clinicians in key clinical areas. NCQA's HEDIS® is the most widely used performance measurement tool in health care.

Community Investments

Since the formation of our CCO, Trillium has invested over \$13 Million in the health of our community. Examples of our investments include:

TRANSFORMATION GRANTS

- PeaceHealth, Bridging patient discharges - Johnson Unit
- OHSU, Novel Interventions in Children's Healthcare - Lane County H&HS, Peer Support System Navigator Program
- ShelterCare, Homeless Medical Recuperation Program
- Clinic Partners, Trillium Integration Incubator Project
- Center for Family Development, Integrated Behavioral Health
- HIV Alliance, HIV/HCV Intervention
- Looking Glass Youth and Family Services, Strategic Treatment Transformation
- Good Samaritan Society, Telehealth Mentoring Services
- Centro Latino Americano, Nuestras Familias (Our Family)
- Cornerstone Community Housing, Healthy Homes
- Daisy C.H.A.I.N., Postpartum Support Services
- Willamette Dental Group, Chronic Condition Dental Management Program

NEW PRIMARY CARE CLINICS

- Brockle Clinic
- Delta Oaks
- Orchid Clinic
- Centennial Clinic
- Oregon Integrated Health

PREVENTION PROGRAMS

- Good Behavior Game (GBG)
- Quit Tobacco In Pregnancy (QTIP)
- Tobacco Cessation Counselor Training
- Coordinated Approach to Child Health (CATCH)
- Nutrition and Physical Activity Self-Assessment for Child Care (NAP SACC)
- Project Piunga Pool Pass Program
- VERB Summer Scorecard
- Double Up Food Bucks
- Community Based Parenting Education
- Family-Check-Up
- Mental Health Coaching for Home Visitors





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Date: May 18, 2018

To: Patrick Allen, Director, Oregon Health Authority
Zeke Smith, Chair, Oregon Health Policy Board
Jeremy Vandehey, Health Policy and Analytics Director, Oregon Health Authority

From: Amanda Cobb, Executive Director, Trillium Community Health Plan

RE: CCO 2.0

Trillium Community Health Plan (Trillium) appreciates the opportunity to submit this memo to the Oregon Health Authority (OHA) and the Oregon Health Policy Board regarding CCO 2.0 policy development. The recommendations included in this memo are shaped by the experiences, efforts, and activities of Trillium and our service area, as well as collaborative discussions with other CCOs. We are proud of the collective efforts undertaken in the first five years of Oregon's health system transformation.

Trillium serves Oregon Health Plan (OHP) members in Lane and Western Douglas Counties. We are a recognized leader of innovative approaches, community collaboration and coordination of community-based healthcare. Trillium has a long history of caring for underserved populations. In 1996, Lane Independent Practice Association funded the creation of Trillium to locally serve OHP members. In 2012, Trillium was one of the first Coordinated Care Organizations (CCOs) approved by the state to transform healthcare.

Trillium has embraced the coordinated care model and has worked with a variety of community partners to develop a continuum of care that addresses the needs of OHP members. Trillium has invested more than \$13 million in Lane County to open five new clinics to ensure all members have access to primary care, expand prevention services targeted at reducing tobacco use and obesity, and further integrate and enhance community behavioral health services – including addressing the holistic needs of our most vulnerable such as housing, education, and access to healthy food. Trillium sets aside \$1.33 per OHP member per month to fund Lane County staff positions, including a prevention specialist, epidemiologist and education program coordinator. The funding also supports evidence-based prevention programs that prevent chronic disease and help Trillium members live healthier lives.

Early in the development of our CCO, Trillium collaborated with Lane County and formed a unique public-private partnership. The partnership has become a model for behavioral health and primary care integration as well as expanding the reach of prevention efforts. Lane County co-located its LaneCare work force within Trillium (known as Trillium Behavioral Health). The result was an innovative model of



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shared accountability delivering physical and behavioral health services to better treat the whole person.

Trillium collaborates with Lane County, PeaceHealth, and United Way to conduct a community health needs assessment and community health improvement plan (CHIP) to determine the most significant health needs of our community. Through this work, Trillium and community partners create innovative solutions to address health disparities and the social determinants of health. Trillium is accomplishing the CHIP goals by:

- Expanding the existing Double Up Food Bucks program, developed in collaboration with Lane County, into rural communities and partnering with our local food bank on new and existing programs that provide access to fresh fruit and vegetables to Trillium members.
- Working with Lane County and the Lane Early Learning Alliance on parenting programs, such as Family Check-up, that help create stable families and have demonstrated promising results, including reduction in adverse childhood events.
- Working with Lane County HHS to implement the Frequent Users System Engagement (FUSE) project to assist homeless members who experience high utilization of health, social and government services. The positive results of the FUSE program has resulted in additional Trillium investment to expand the project.
- Utilizing the Regional Health Equity Coalition model to address social determinants of health and health disparities through a collaborative project with the CHIP partners known as the Lane Equity Coalition (LEC).

Trillium supports the vision of the Oregon Health Authority to continue work on the foundational principles of the coordinated care model: achieve our shared goals of reducing health disparities while coordinating better care and better health at lower costs. The foundational principles of care coordination, access, measurement, prevention and value remain critical to continued transformation and growth. Across Oregon, CCOs achieved marked improvements in quality and access to care and collectively contained costs to 3.4 percent within the first five years of transformation. However, we believe there is continued opportunity to improve and refine our delivery system efforts to achieve the original vision of health system transformation.

CCO 2.0 and Lessons Learned

Trillium is pleased to share ideas for improving the CCO model. Below please find recommendations framed by each CCO 2.0 policy focus area to help expand and improve our Oregon CCO efforts.

Improve the Behavioral Health System

Trillium and other CCOs have made great strides in the area of behavioral health, but there are challenges that need particular attention to adequately address the behavioral health needs of OHP members. These challenges include:

- deficiencies in the system of care resulting from program closures;



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- workforce recruitment and retention challenges;
- disproportionately low funding allocations; and
- limited interoperability within the system of care.

We believe CCOs and state partners must continue to promote cross system collaboration, investment, and accountability at the state level to allow local innovations to thrive. Trillium offers the following behavioral health recommendations, including support for Oregon child and youth system of care improvements and general CCO behavioral health integration and access concepts:

- Consider structural and process measurements to better evaluate CCO infrastructure and service delivery to support behavioral health integration and assist providers in developing structural components for measuring health outcomes in a standardized manner.
- Create cross system accountability and blend/braid funding streams managed by Department of Human Services and OHA to create an array of treatment services to support children in their homes and communities. Braided funding will help communities to build local systems of care for children with serious behavioral health care needs.
- Targeted expansion of Psychiatric Residential Treatment Services and Secure Children's Inpatient Services.
- Encourage Child Welfare to work with CCOs to assist in care coordination and provide behavioral health treatment services to families -- where parents or children are enrolled in the CCO -- prior to removal of the children.
- Provide additional resources for the Intellectual/Developmental Disabilities system to ensure timely access to assessment and placement to help avoid long lengths of stay in acute care and emergency departments.
- Clearly define behavioral health integration (considering the inclusion or exclusion of specialty mental health and addictions) beyond medical treatment to include partnerships necessary to affect changes in social determinants of health and prevention. The definition should include measurements of success.
- Provide financial and technical assistance to improve electronic health record functionality. The behavioral health system needs financial and technical assistance to increase the use of electronic health records and interoperability within the system of care.
- Clarify roles of Local Mental Health Authorities and CCOs. Statutory and contractual requirements outline differences between the two entities, but there is an opportunity to define other areas that are not included or clearly delineated.
- Increase state financial allocations to ensure the behavioral health system can recruit, train, and sustain a workforce and expand services to address unmet needs. Alternatively, allow CCOs to



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accrue savings within their global budget to prioritize these investments without penalties during the rate development process.

- Comply with the USDOJ Performance Plan requirements and increase coordination with CCOs to operationalize and track successful implementation of the Oregon Performance Plan.
- Improve payment mechanisms for traditional health workers (THWs). Modifications to encounter codes and Medicaid provider requirements will allow for the sustainable administration of THW services.
- Educate CCOs and providers on allowable information sharing between behavioral health and physical health providers. HIPAA and 42 CFR Part 2 protect patient privacy but also provide a workable framework for information sharing and coordination of care.

Focus on Social Determinants of Health and Equity

Trillium believes we have a responsibility to remove barriers and make it simple to get well, stay well, and be well. We will continue to invest resources to coordinate high quality healthcare and assist our community to address social determinants and health equity needs but OHA support is critical. Investments in non-covered services and partnership development addressing the social determinants of health may lead to efficiencies and cost savings in the healthcare system. However, CCOs may be negatively impacted when they invest in initiatives that result in a decline in the cost basis for future rates (premium slide). OHA can further support CCOs in sustaining existing efforts and expanding activities in this area with the following:

- Achieve the original vision of the global budget to develop the funding structures that will offer CCOs the flexibility to invest upstream. Creating the appropriate flexibilities within rate setting and CCO budgets will promote a focus on the needs of members and communities.
- Assure investments in non-covered services and the social determinants of health will be counted positively towards rate setting. Providing specific guidance to the CCOs that explains how non covered services will be accounted for within the medical and non-benefit load and in the Medical Loss Ratio calculation.
- Work with CCOs to implement a gain augmentation program, as required by the 2017 1115 waiver, that will prevent premium slide in future years and reward CCOs that are improving quality and efficiency through investments in non-covered services and other means.
- Reduce regulatory and/or programmatic barriers to blended/braided funding with state agencies addressing social determinants of health (e.g., Department of Human Services and Oregon Housing and Community Services) and increased cross-sector data sharing to coordinate with non-health care sectors.



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- Develop specific guidance for CCOs interested in making community investments to create housing infrastructure and provide supportive housing services to at-risk adults and families. The guidance can focus on clearly defining billable supportive housing services and non-covered services that would be classified as a health-related service.
- Allocate staff and funding resources to support cross-agency work with Oregon Housing and Community Services in the development of a statewide strategy for supportive housing.
- Provide resources and technical assistance through the Office of Equity and Inclusion to assist in health system transformation.
- Explore opportunities to collect OHP member demographic information to enable CCOs to better address equity needs.

Increase Value and Pay for Performance

As Oregon moves forward with development of the VBP Roadmap, we believe it is important to ensure state-led Medicaid efforts are aligned with federally-led VBP strategies. This will increase the likelihood of provider engagement and achievement of VBP goals. In particular, alignment of quality measures across Medicare, Medicaid and commercial payers is an opportunity for multi-payer coordination in VBP. Alignment across quality measures would decrease duplication of efforts and administrative burden for providers and CCOs.

In the first five years, CCOs have worked to implement APM and VBP requirements. As we seek to expand the use of these models, there are barriers that need to be addressed. We believe it is important that CCOs and providers have the flexibility to develop VBP models based on local needs and resources. Local control will allow for development of the most appropriate VBP arrangements reflecting service area health IT infrastructure and resources, capacity to share risk, Medicaid volume and local healthcare spending trends.

In addition to the recommendations above, OHA can also support CCOs in value-based payment adoption with the following:

- Align financial reporting and rate setting processes to support adoption of VBPs. To facilitate CCO adoption of VBPs, we recommend modifying existing financial reporting templates to acknowledge and account for VBP arrangements.
- Conduct an environmental scan to identify a standardized VBP target that allows incremental progress over a multi-year period. In the immediate future, it may not be feasible to incorporate a CCO specific target without conducting an environmental scan that would allow each CCO to determine improvement goals based on member needs as well as operational and delivery system considerations.



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- Work with providers and CCOs to develop a validated methodology to determine meaningful levels of provider downside risk in shared risk arrangements. This may include consideration of payer mix, size, competition and other factors impacting the provider network.
- Engage CCOs in additional discussions to develop common definitions and guidelines for payment categorization based on HCP LAN framework. It would also be helpful for ongoing work to identify reporting requirements for regular and supplementary reports, including the development of an annual narrative report to describe VBP progress.
- Develop episode-based and condition-specific payments for the delivery system, including, but not limited to, specialty care and hospital care. Trillium supports the OHA proposal to create an incentive for CCOs to implement a maternity care case rates or episode based payments for professional and facility care and costs.
- Avoid requirements that mandate or encourage specific CCO-provider contract language regarding provider compensation arrangements. We recommend OHA work with providers and CCOs to mitigate any unintended consequences of CCO provider contract incentives with affiliated provider payment and/or compensation.

Maintain a Sustainable Cost Growth

To support future investments in activities, programs, and efforts that reduce overall costs to the healthcare system, we recommend adjustments to the rate setting process to encourage CCOs to continue making investments in programs and activities that contain costs for the overall system. To date, CCOs have limited their investments in the area of health-related services because any increased spend has not been included in the medical base data informing rate calculations. Adjustments to the rate setting process to compensate CCOs for these additional investments may provide greater flexibility in the use of health-related services as a mechanism to address the social determinants of health and contain costs.

The 3.4 percent sustainable rate of growth implemented at the start of health system transformation has resulted in significant cost savings to the state and the federal government. As required by Oregon's 1115 waiver, the state should maintain the 3.4 percent sustainable rate of growth at the statewide program level, but consider adjustments to the methodology to exclude high-cost drivers. CCOs are unable to curb the total cost trend because several major cost drivers are beyond CCO control. These drivers include: enrollment discontinuity, pharmaceutical cost growth, members with complex care needs and high costs, A/B hospital reimbursement, among others. For example, the cost of pharmaceuticals continues to rise 10 times the rate of inflation, representing a significant portion of CCO budgets. We support OHA and CCO collaboration to develop creative solutions to address pharmaceutical cost growth and its impact on the Oregon Medicaid budget, individual CCO budgets and the sustainable rate of growth.



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Additionally, we do not recommend inclusion of the sustainable rate of growth as a contract requirement for each CCO. The calculation has historically been based on an average of statewide CCO cost increases, not on CCO-specific cost growth. Individual CCO costs vary substantially and fluctuate from year to year. There is currently no mechanism to increase reimbursement in years where growth falls below the rate of growth target.

In addition to the recommendations above, OHA can also support CCO sustainable cost growth efforts with the following:

- Work with CCOs to understand the barriers to implementation of the original goals of the global budget and create flexibilities to encourage CCO investment in non-covered services that improve health outcomes and reduce costs.
- Implement a gain augmentation program, as described in the 1115 waiver, to reward CCOs for improvements in efficiency and quality. Without such adjustments to the rate setting process, increased investments to integrate physical and behavioral health services, address the social determinants of health, and adopt VBP arrangements may not be sustainable.
- Work closely with CCOs to identify the costs included in the calculation of the rate of growth and clearly state excluded costs to ensure uniformity across CCOs. Increased investments in non-covered services to address the social determinants of health may lead to increased costs over time since these efforts frequently require several years to see a return on investment. Reporting requirements for Exhibit L do not follow standard insurance reporting guidelines and often lead to differences in reporting of costs among CCOs. Continued work between OHA and CCOs to establish clear guidelines for reporting will ensure all CCOs report standardized information and will allow for comparison across CCOs.
- Consider increasing baseline CCO reserve requirements to provide greater consumer and provider partner protection.
- Increase identification and reporting of high-cost trends to all CCOs. Greater OHA transparency on high-cost trends across all CCOs would improve CCO provider network management and support CCO cost containment efforts. To support information sharing across CCOs, OHA could provide technical assistance and develop learning collaboratives to encourage development of strategies to address high-cost trends.
- Continue collaboration and discussion regarding changes to the existing Quality Pool program. Trillium supports OHA goals to tie incentives for both CCOs and providers to successful performance on quality metrics aligned to the goals of the CCO program. In particular, we welcome the opportunity to work through the details of proposed changes to the Quality Pool program to ensure:
 - Quality Pool dollars benefit CCOs and providers who perform the most effectively on quality pool metrics;



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- Rate setting processes support these aims with careful consideration for how expenditures from quality pool funds are averaged into the base data to prevent any adverse consequences for high performing CCOs and providers; and
- Rates are actuarially sound by taking into consideration portions of any withhold that are not reasonably achievable and portions of the withhold that CCOs share or are expected to share with providers for their metrics performance.

Continuing the Collaboration

On behalf of the CCO members and communities we serve, Trillium greatly appreciates the opportunity to provide feedback on CCO 2.0. Again, the recommendations included in this memo are shaped by the experiences, efforts, and activities of Trillium and our service area, as well as collaborative discussions with other CCOs. We are happy to discuss any specific questions regarding our recommendations. We look forward to continuing to collaborate on the future of our Oregon CCO program.

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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Clear ownership of BH benefit by the CCO OPP to be included in 2019 CCO contract extension BH 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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
		<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • Require one statewide priority – housing-related supports and services – plus community priority(ies) 	5 ◆ * ‡
	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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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 ∞ *
How do we better ensure provider	Development of CCO internal infrastructure and investment to coordinate and support CCO equity activities and build	<ul style="list-style-type: none"> Each CCO will establish permanent structures to advance health equity, including: <ul style="list-style-type: none"> Single point of accountability for health equity with budgetary decision making authority and health equity expertise. 	5 ∞ *
	Improve health outcomes through community health assessment (CHA) and community health improvement plan (CHP) collaboration and investment.	<ul style="list-style-type: none"> 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 ∞ *

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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.	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Implement recommendations of the THW Commission, including requiring CCOs to: <ul style="list-style-type: none"> 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.	<ul style="list-style-type: none"> 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	<ol style="list-style-type: none"> 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 <ul style="list-style-type: none"> • 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 <i>Supporting rationale:</i> Payments to CCOs,	<ol style="list-style-type: none"> 1. Evaluate efficiency and total costs of care to establish variable profit margins based on CCO performance <ul style="list-style-type: none"> • 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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	<p><i>hospitals and other providers should reward and incentivize efficient delivery of care and use of services with highest clinical value</i></p>	<ol style="list-style-type: none"> 2. Incentivize health care services with highest clinical value by rewarding their use in rate setting <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ 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 orthopedicsurgery, and inappropriate tests and/or screenings outside clinical guidelines. 3. Increase the portion of hospital payments that are based on quality and value <ul style="list-style-type: none"> • Incorporate quality and value measures in calculating reimbursement to hospitals (includes CCO and OHA directed payments). 	
<p>Quality Pool Payments & Structure</p>	<p>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</p>	<ol style="list-style-type: none"> 1. Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development in order to: <ul style="list-style-type: none"> • 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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<p>Mitigating Financial Risk & Outlier Costs</p>	<p>Spread and manage risk related to low frequency, high-cost conditions and treatments</p>	<ol style="list-style-type: none"> 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 <ul style="list-style-type: none"> • Value potentially limited to targeted conditions and/or services 3. Address increasing pharmacy costs and the impact of high-cost and new medications <ul style="list-style-type: none"> • Ongoing policy development & follow-up based on future OHPB committee 	
<p>Financial Reporting and Reserves</p>	<p>Enhance alignment of CCOs risk and financial requirements to ensure CCO solvency, accountability, and consistency of data</p>	<ol style="list-style-type: none"> 2. Enhance current reporting tools: <ol style="list-style-type: none"> A. Building on existing reporting templates (i.e., Exhibit L) and reevaluate reserve requirements and calculations to better account for risks CCOs bear <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> • 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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<p>Ensuring Accurate and Sufficient Encounter Data</p>	<p>Consistent and accurate reporting of services provided and their associated costs</p>	<ol style="list-style-type: none"> 1. Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy (AZ Model) with financial implications <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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? <i>CCO payments to providers: Targets</i>	Increase CCOs' use of VBPs with their contracted providers	<ul style="list-style-type: none"> 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? <i>CCO payments to providers: Policy areas</i>	Increase the use of VBPs to improve health outcomes in key care delivery areas	<ul style="list-style-type: none"> Require CCOs to implement one VBP focused on these key care delivery focus areas: <ul style="list-style-type: none"> 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 	5 ♦ ∞ *
What changes to data collection are necessary to track progress on, and improve our	Assess CCOs' progress toward the statewide VBP	<ul style="list-style-type: none"> 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? <i>CCO payments to providers: Data</i>	goal and CCO-specific VBP targets	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> • 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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