

2014 Coordinated Care Model Alignment Workgroup

September 17, 2015
2:00 p.m. – 4:00 p.m.

Lincoln Building (Transformation Center Training Room – Suite 775)
421 SW Oak Street
Portland, OR 97204

Public listen-only conference line: 888-363-4734; Participant code: 1050791

#	Time	Item	Lead
1	2:00	Updates and Group Discussion <ul style="list-style-type: none">• Executive sponsor transition• Identifying additional tools for purchasers	Leslie Clement, OHA Veronica Guerra, OHA
2	2:15	Review Model Contract Language	Beth Waldman, Bailit Health Purchasing
3	2:45	Informing the Oregon Business Plan Health Care Strategic Framework <ul style="list-style-type: none">• Setting the stage – where we have been and where we are today• Future direction and strategies<ul style="list-style-type: none">○ Discussion questions:<ul style="list-style-type: none">▪ What are Oregon's biggest challenges in health and health care?▪ What strategies should receive focused, shared attention across business, providers, insurers, and the state in the next two to five years?<ul style="list-style-type: none">– What are the short-term priorities? (one to two years)– What are the long-term priorities? (three to five years)• Next steps	Gretchen Morley, OBC Diana Bianco, Artemis Consulting
4	3:50	Public Comment	
5	4:00	Adjourn Meeting	

Meeting materials:

- Model contract language
- OBP health care strategy working matrix
- Summary of Fall 2015 OBP health care strategy reset
- Slides for Fall 2015 OBP Reset Input Session

Next meeting dates:

- March 17, 2016 2:00-4:00pm
- June 16, 2016 2:00-4:00pm

Draft Model Contract

Introduction to Model Contract:

The purpose of this Model Contract is to assist self-funded employers to implement aspects of the Coordinated Care Model (CCM)¹ through an agreement with a Third Party Administrator (TPA). Many of the terms of this Contract could also be used by fully-insured employers in agreements with health insurers.

Key elements of the CCM include:

- Best practices to manage and coordinate care
- Sharing responsibility and engaging members in better health
- Measuring provider performance
- Paying for outcomes and health
- Providing information to Participants about price and quality
- Financially sustainable rate of health care cost growth (per member)

The Model Contract, which goes beyond a Scope of Work, includes the following key elements of a Contract based on CCM principles.

- **Contract Purpose:** This section lays out the purpose of the Contract and the goals that the employer is trying to accomplish through the Contract.
- **Comprehensive Services:** This section details the services that the employer will provide as covered services under the Contract. This language provides optional language for employers to consider on regarding member selection of a primary care physician, different benefit design incentives, and potential cost-sharing structures.
- **Network Management:** This section includes requirements for the TPA to provide an adequate network to serve the employer's covered population and requirements related to managing the provider network.
- **Evidence-Based Care:** This section is focused on requirements to provide evidence-based care, and the monitoring of adherence to those requirements.

¹ For more information on the CCM, please see <http://www.oregon.gov/DAS/PEBB/2015Benefits/Coordinated%20Care%20Model.pdf>

- **Quality:** This section provides the quality requirements for the TPA, including implementation of a Quality Improvement Plan and use of standardized quality measures to assess plan and provider performance.
- **Payment Strategies:** This section provides options that employers may require for value-based payment strategies, including population-based payments, pay-for-performance, episode-based payments, strategies designed to reduce waste, and strategies designed to support primary care.
- **Health Information Technology:** This section focuses on the HIT requirements for the TPA as well as for network providers, including use of electronic health records, information sharing and analysis.
- **Transparency:** This section provides employer requirement options regarding disclosure of provider performance and price to facilitate Participant comparisons.
- **Contractor Performance:** This section describes how the employer will monitor the TPA's performance, and apply financial consequences to performance through performance guarantees and financial incentives and disincentives.

There are a number of other standard requirements that should be included in a TPA Contract, but are not addressed here because they concern standard administrative services and are not specific to the CCM, For example, TPA contracts should address customer services, development of a provider directory, claims payment and other IT infrastructure, provision of encounter data, and confidentiality requirements. Employers should work with their TPA to ensure that the Model Contract is supplemented with additional information about these services that would be required in a Contract.

Where the Model Contract includes explanatory language for the purchaser that would not be part of a Model Contract, it is marked with brackets and in italics. Recognizing that purchasers will be in different places and comfort levels with some aspects of the Coordinated Care Model, there are a number of elements marked “Alternative” or “Optional”, throughout the Contract. Alternative language can be substituted for the model language directly above it in order to make a stronger requirement. Likewise, Optional elements are those that can be added in addition to the model language to make a stronger requirement. Both alternative and optional elements are also identified by use of italics.

Definitions

Behavioral Health means services related to either mental health and/or addiction services.

Care Management means services for Members with one or more chronic medical conditions (including but not limited to diabetes, chronic obstructive pulmonary disease, congestive heart failure and hypertension) and are at high risk of future inpatient and Emergency Department (ED) use. Such services include coordination of care, patient engagement and addressing social determinants of health, all with the goal of improving the Member's health status and averting the need for avoidable future inpatient and ED utilization.

Case Management means a program that supports Members with complex acute health care needs who require a case management process that fully integrates medical, behavioral, acute care, medication management and patient education into a seamless experience, ensuring Members receive the right care at the right time, are engaged, understand the care plan and receive ongoing support from their care team in order to prevent avoidable future inpatient and ED utilization.

Clinical Protocols means standardized tools designed for a particular medical condition or procedure that provides clear care guidelines based on scientific evidence and organizational consensus regarding the best way to manage the condition or procedure.

Concurrent Review means the review of a service, typically in a facility setting, while a Participant is in that setting to confirm that the service is medically necessary and reimbursable under the Plan.

Coordinated Care Model (CCM) means a model of care delivery through which purchasers, health plans and providers work collaboratively to get better value and higher quality of care at an affordable price. The key elements of the CCM include best practices to manage and coordinate care, shared responsibility for health, transparency in price and quality, measuring performance, paying for outcomes and health and a sustainable rate of growth.

Electronic Health Record is a digitalized health record for an individual that may be shared among health care providers.

Employer means a sponsor of a group health plan with specified benefit coverage through the TPA.

Episode-based Payment means payment for a group of related services that are bundled together to treat a specific intervention. An example of an Episode-based Payments is one payment for a set of maternity care services (pre-natal, delivery and six weeks post-natal).

Evidence-Based Care means the conscientious, explicit and judicious use of current best evidence in making decisions about the care of patients, including to find, assess and implement

methods of diagnosis and treatment.

Motivational Interviewing means a directive client-centered counseling approach that elicits behavior change by helping clients to explore and resolve ambivalence.

Participant means employees, dependents and retirees of the Employer who receive their health benefits under the Plan.

Patient-Centered Primary Care Home (PCPCH) means a health care team or clinic, as defined in ORS 414.655, that meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.

Pay for Performance means a program through which the TPA rewards Network Providers for meeting or exceeding targeted performance on specific quality measures.

Plan means the set of benefits offered by the Employer through the TPA through an agreement.

Population-based Contract: means a payment arrangement where the TPA contracts with a provider who agrees to accept responsibility for a set of health services for a group of patients in exchange for a set amount of money. If the provider effectively manages cost and performs well on quality of care targets, then the provider may keep a portion (or all) of the savings generated, but if the provider does not perform well then it may be held responsible for some (or all) of the additional costs incurred.

Prior Authorization means the pre-review of a service for medical necessity to determine whether it is reimbursable under the Plan.

Primary Care Clinician (PCC) means a clinician, including a physician, nurse practitioner or physician assistant, who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients, and practicing in the context of family and community, as recognized by a State licensing or regulatory authority.

Provider Network means the groups of primary care and specialty physicians, hospitals, outpatient and ancillary facilities participating in the TPA's network for the purposes of this Plan.

Team-based Care: The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across settings to achieve coordinated high-quality care.

Telehealth means the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology.

Third Party Administrator (TPA) means the entity responsible for providing Plan administration services on behalf of an Employer and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Participants.

Value-based Network Design means the explicit use of employee health care plan benefits to create consumer incentives for the use of high performance providers who adhere to Evidence-based treatment guidelines.

Value-based Plan Design means the explicit use of plan incentives to encourage enrollee adoption of one or more of the following, including but not limited to:

- appropriate use of high value services, including certain prescription drugs and preventative services;
- adoption of healthy lifestyles, such as smoking cessation or increased physical activity; and
- use of providers who adhere to evidence-based treatment guidelines.

Model Contract Provisions

I. Contract Purpose

[Employer Name] (Employer) is entering into this Contract with [TPA name] (TPA) for the purpose of purchasing a value-based health insurance product for its employees and dependents that includes the key elements of the Coordinated Care Model (CCM) with a primary objective of improving health care outcomes and quality while reducing costs. Key elements of the CCM include:

- Best practices to manage and coordinate care
- Sharing responsibility and engaging members in better health
- Measuring provider performance
- Paying for outcomes and health
- Providing information to Participants about price and quality
- Financially sustainable rate of health care cost growth (per member)

Employer purchasing strategy is focused on the fundamental belief that collaboration is essential to providing affordable, value-added benefits. Employer seeks to utilize the services of [TPA] to help meet its goal of purchasing care through a healthcare delivery system that is accountable for costs and outcomes.

TPA agrees to partner with Employer in its efforts to achieve better health, better care and lower costs consistent with the principles laid out above.

II. Comprehensive Services

[This section of the Contract will detail the services that the employer wishes to purchase, consistent with the CCM. At a minimum, employers should ensure that the following contract language guides their purchasing activities and contractual arrangements with a TPA. Additional language has been developed (denoted as optional) for some of the areas below that can be adopted by employers wishing to be more transformative in their benefit purchasing and design]

- a. **Covered Services:** TPA shall arrange for provision of all of the services listed in Appendix A.
- b. **Primary Care Clinician (PCC):**
 - i. All Participants shall be required to identify a personal PCC.
 - ii. Contractor shall develop a process through which plan participants select a PCC.

1. The Contractor's provider directory shall include all available PCCs within the Contractor's network. As detailed in Section III below, the provider directory shall include information to assist a Participant in selecting the most appropriate PCC for his or her needs.
 2. The Contractor shall provide the Participant with information on how to select a PCC upon enrollment, including but not limited to:
 - a. How long a Participant has to select a PCC
 - b. How the Participant selects the PCC
 - c. How a PCC will be assigned to Participants who do not select a PCC.
 - d. Whether and how often a Participant shall have the option to select a different PCC.
 3. The Contractor shall require PCCs to reach out to Participants who have selected or been assigned to them specifically to establish a relationship with each attributed Participant should the PCC have never treated the Participant. The requirement shall describe how the PCC is expected to reach out to patients and the timeframe for doing so.
- c. **Care Management Services:** TPA shall provide Care Management for patients at high-risk of future intensive service use.
- i. TPA shall identify Participants for Care Management based on:
 1. Presence of one or more poorly controlled chronic conditions, including:
 - a. Asthma
 - b. Diabetes
 - c. Coronary Disease
 - d. Chronic Obstructive Pulmonary Disease
 - e. Heart Failure
 - f. Depression
 - g. Chronic Pain
 - h. Substance Use
 2. Complex hospital course, length of stay, or unplanned hospital admissions;
 3. Review and identification of high cost cases;
 4. High volume emergency department utilization (six visits in three months); and/or
 5. Referral from providers, family members or the Participant.
 - ii. TPA shall work with identified Participants to actively engage them in Care Management services focused on improving or stabilizing the

Participant's health and securing appropriate and cost-effective services, supplies and treatment.

1. TPA shall make at least three attempts, at different times of the day, using different methods to engage Participants in care management.
- iii. For Participants identified for and engaged in Care Management services the TPA shall assess Participant's health status, develop a plan of care, provide specific interventions as appropriate based on an individual's particular care needs, and provide education and self-management skills, coordination, facilitation and ongoing supports to the Participant.
 1. *TPA's care managers shall use evidence-based practices, such as motivational interviewing, to enhance their ability to engage Participants in self-care (Optional).*
- iv. TPA may provide Care Management itself, or in combination with a coordinated provider entity. In providing care management, TPA shall work closely with providers to avoid duplication of services.
 1. TPA shall develop and share protocols for coordinating care management services with its Provider Network, including PCCs. Such protocols should provide flexibility on a case-by-case basis as needed to best serve the Participant.
- d. **Case Management Services:** TPA shall provide Case Management for Participants who would benefit from care coordination and navigation services.
 - i. TPA shall identify individuals that do not meet the requirements of Care Management Services but may benefit from Case Management.
 1. Individuals may be identified based on claims history, including lack of claims for certain services (such as PCP visits, appropriate screenings) or high use of the emergency department.
 2. Individuals may also be referred to Case Management through referrals from customer service, providers, family members or self-referrals from Participants.
 - ii. TPA shall assign a case manager to work with identified Participants to actively engage them in Case Management services focused on assisting Participants with accessing care and making linkages with appropriate community-based services.
- e. **Integration of Physical and Behavioral Health Care:** TPA shall ensure that an increasing percentage of PCC in the Provider Network offer behavioral health and primary care services that are integrated through the application of evidence-based best practice strategies.

- i. TPA shall encourage co-location of physical and behavioral health care professionals, integrated medical records, use of a shared treatment plan, and integrated payment models.
 - 1. *TPA shall also encourage reverse co-location (that is primary care providers within a behavioral health site). (Optional)*
 - 2. *To encourage integration, TPA shall implement an enhanced fee and/or technical support, funded by Employer, to Network Providers that participate in alternative payment models that integrate physical and behavioral health care. (Optional)*
- f. **Formulary Development:** TPA shall cover prescription drugs included in a drug formulary developed for Employer, with covered prescription drugs and cost-sharing amounts that supports a value-and evidence-based purchasing strategy.
 - i. The TPA shall allow access to prescription drugs outside of the formulary for special circumstances.
 - ii. The TPA shall review the formulary at least annually.
- g. **Use of Telehealth:** Where appropriate, TPA shall authorize services to be provided through Telehealth to reduce barriers to treatment, including access issues caused by wait times and travel times to the nearest provider.

III. Network Design and Management

This section of the Contract will detail the required network and how the Plan should manage its provider network. The TPA shall provide Employer with the opportunity to review and approve the methods it will use to meet and monitor these requirements over the course of the Contract.

- a. **Provider Network.** The TPA shall make available to Participants a Network of Providers sufficient to deliver timely access to the health services covered by the Plan and detailed in Appendix A. The TPA shall provide sufficient access for routine, urgent and emergent care within a reasonable geographic coverage area.
 - i. At a minimum, the Provider Network shall include:
 - 1. Primary care;
 - 2. Specialty care;
 - 3. Ancillary services, including community and home-based services;
 - 4. Inpatient and outpatient facility care;
 - 5. Skilled nursing and rehabilitative care;
 - 6. Pharmacies; and,
 - 7. Behavioral health care (including mental health and substance use services).
 - ii. The TPA will ensure adequate access by:
 - 1. Requiring providers to deliver emergent care;

2. Requiring providers to offer same-day appointments for routine and urgent services for both medical and behavioral health care;
 3. Requiring providers to offer appointments outside of regular business hours;
 4. Providing access to services through telemedicine, where appropriate; and,
 5. Identifying and acting on opportunities to improve access.
- iii. The TPA will monitor the adequacy of the Network on an ongoing basis.
 - iv. The TPA shall provide Employer with notice of material changes to the Network in advance, or as soon as reasonably possible.
 1. Such notice shall include an analysis of the remaining Network's capacity to serve Participants.
 2. Such notice shall include a plan to ensure appropriate transfer of a Participant's care in a way that is timely and burden-free for the Participant.
- b. Patient Centered Primary Care Homes.** TPA shall encourage its PCPs within its Network to operate as high-functioning Patient Centered Primary Care Home (PCPCH) or as part of another patient centered medical home (PCMH) initiative.
- i. At a minimum, 65% of the Employer's group shall receive primary care services through high-functioning PCPCHs by Year 2.
 1. *Alternative: The number of Participants receiving care through a PCPCH could be modified:*
 - a. 85% (very aggressive)
 - b. 75% (moderately aggressive)
 - ii. The TPA shall support PCPCHs with information, including but not limited to high-risk patient lists, comparative costs of referral providers, and utilization, quality and cost measures for attributed Participants.
 - iii. The TPA shall hold PCPCHs accountable for performance.
 - iv. *The TPA shall support an increasing number of PCPCHs in its Network over the term of the Contract and shall support PCPCHs in achieving the highest level of medical home certification as defined by OHA or other commonly used guidelines, through use of enhanced fees, supplemental payments and/or technical assistance support. (Optional)*
 1. *Alternative Language: The TPA shall support an increasing number of PCPCHs in its Network over the term of the Contract and shall support PCPCHs in achieving the highest level of medical home certification as defined by OHA or other commonly used guidelines, by providing financial support (differentially based on the tier level achieved) to PCPCHs for meeting the PCPCH standards.(Optional)*

- c. **Team-based Care:** TPA shall encourage its Network Providers, beyond PCPCHs, to provide patient-centered, team-based care across appropriate disciplines through the application of a common, shared care plan and clinical information exchange.
 - i. *TPA shall provide trainings for Network Providers related to the clinical evidence supporting patient-centered team-based care and how to transform their practices to meet such requirements (Optional)*
 - ii. *TPA shall require an increasing number of its Network Providers to practice patient-centered team-based care over the life of the Contract (Optional). Stronger alternatives to this language:*
 - 1. *TPA shall require all Network Providers to provide patient-centered, team-based care (Extremely Aggressive)*
 - 2. *TPA shall require its Network Providers to provide patient-centered, team-based care by Year 3 of the Contract (Very Aggressive)*
 - 3. *TPA shall have 75% of its Provider Network providing patient-centered, team-based care by Year 3 of the Contract (Aggressive)*
 - 4. *TPA shall have 50% of its Provider Network providing patient-centered, team-based care by Year 3 of the Contract (Moderate)*
 - 5. *TPA shall have 25% of its Provider Network providing patient-centered, team-based care by Year 3 of the Contract (Easiest).*
 - iii. TPA shall develop and implement a monitoring plan to assess its Provider Network's progress in implementing team-based care.
- d. **Value-Based Network Design:** *The TPA shall have the capacity to implement varied cost-sharing for Network Providers by provider performance. (Optional)*
 - i. *The TPA shall review provider quality performance and tier providers into three levels based on performance using a methodology approved by the Employer.*
 - ii. *Providers at the highest quality tier based on performance shall have the lowest cost sharing; providers with the lowest performances shall have the highest cost sharing.*
 - iii. *At Employer request, the TPA shall develop a high-performing network limited to providers who distinguish themselves as high quality providers based on evidenced-based, statistically meaningful and risk-adjusted measures of quality, cost and efficiency.*
- e. **Provider Directory:** The TPA shall provide a web-based directory of Network Providers available under the Plan, and will make regular updates to the directory. At a minimum, the provider directory shall include the following information:
 - i. Provider name and location
 - ii. Provider type, specialty area and certifications, if any

- iii. Languages spoken
- iv. *Provider tier (optional)*

IV. Evidence-based Care

This section of the Contract will detail requirements for implementation of best practices and how the performance of those activities by Network Providers will be monitored.

- a. **Health Risk Assessment (HRA):** TPA shall offer a self-reported HRA to each Participant.
 - i. The TPA shall identify an HRA that collects sufficient information regarding a Participant's demographics, chronic diseases, injury risks, modifiable risk factors and urgent health needs to identify potential need for complex care management or other services, and to develop a personalized prevention plan for Participants.
 - ii. The HRA must be written at a 6th grade level and all questions in the HRA must be actionable, i.e., have a corresponding evidence-based strategy.
 - iii. The HRA should be available through web-based, interactive telephone or paper-based systems and take no more than 20 minutes to complete.
- b. **Patient Activation and Shared Decision Making:** The TPA shall implement and shall require its Network Providers to use strategies that activate and engage Participants in their health, including through health behaviors that modify risk factors and self-management of any chronic conditions.
 - i. The TPA shall provide and require its Network Providers to offer services in a culturally competent manner that meaningfully and actively engages Participants.
 - ii. The TPA shall support Network Providers in patient activation through a combination of training and standardized tools, including tools that support shared-decision making.
 - 1. The TPA and its Network Providers shall solicit Participant preferences with respect to functional outcomes, recovery or rehabilitation expectations, and risk tolerance;
 - 2. The TPA and its Network Providers shall explain treatment options as may be clinically recommended based on Participant risk profile and/or disease state progression; and,
 - 3. The TPA shall monitor claims and referral patterns to identify opportunities to support decision making around treatment options.
- c. **Medical Management:** The TPA shall provide the following basic medical management services, except in those instances in which the TPA has delegated one or more of the following responsibilities to a qualified provider entity that has contracted using an alternative payment model:

- i. Clinical Protocols: TPA shall identify and implement Clinical Protocols² with its provider network that are evidence-based, designed to maximize patient health status, clinical outcomes and efficiency, and reduce overuse of services. Such protocols shall be in addition to practice guidelines used for prior authorization and concurrent review processes.
 - 1.
- ii. Prior authorization: TPA shall develop policies and procedures related to prior authorization, including when and how prior authorization shall be required.
 1. *The TPA shall consider the coverage guidelines established by the Health Evidence Review Commission (HERC) in developing its prior authorization process (Optional: stronger language may say “require” instead of consider)*
 2. *TPA may exempt certain providers from obtaining prior authorization based on the historical appropriateness of requests, its overall quality scores and use of alternative payment methodologies. (Optional)*
- iii. Concurrent review: TPA shall conduct initial and current reviews of medical and surgical inpatient hospital and skilled nursing facility stays to determine the appropriateness of the setting, level of care and length of stay.
 1. *TPA may exempt certain providers from concurrent review based on historical appropriateness of admissions, its overall quality scores and use of alternative payment methodologies. (Optional)*
- iv. Discharge Planning and Transition Management: TPA shall ensure that there is appropriate discharge planning and coordination between the TPA, the facility, community-based providers and care managers, where appropriate, to assure safe transitions and decrease the risk of avoidable re-admission.

V. Quality and Performance Measurement

This section of the Contract will detail the requirements for monitoring the quality of care provided to Participants and efforts to improve that quality.

- a. **Quality Oversight:** The TPA shall have a strategy for quality oversight of the care being provided to Participants by Network Providers.

² *Examples of clinical protocols may include treatment plans for those with COPD or for stroke management, among others.*

- i. The TPA shall develop an annual quality strategy and maintain quality staff to implement that strategy.
 - 1. The quality strategy should include details on how the TPA shall monitor quality and describe the TPA's Quality Improvement Program (QIP).
 - 2. On an annual basis the TPA shall report to Employer the quality improvement projects it has undertaken during the year and its progress on those activities.
 - ii. Quality Improvement Program: On an annual basis the TPA shall identify 4 QIPs focused on improving Participants' health outcomes.
 - 1. *At least one QIP shall focus on improving health outcomes for Participants with more than one chronic condition. (Optional)*
 - 2. *At least one QIP shall focus on reducing preventable hospital admissions and readmissions. (Optional)*
- b. **Performance Measurement.** Comprehensive performance measurement, aligned across payers, supports identification of performance improvement opportunities and provider performance accountability purchasers while easing the burden of reporting for providers.
- i. The TPA shall utilize performance measures to monitor Network provider quality performance. Measures shall be endorsed by the National Quality Forum or another national body. Measures shall address the following domains of performance: preventive care, chronic illness care, mental health and substance use treatment, efficiency, overuse, patient experience, medication management, access, utilization and coordination of care.
 - ii. The TPA shall report the following cost measures: total charges, total payments, payments per Participant, and payments by place of service, type of provider, diagnostic category, and high volume provider.
 - 1. Alternative: The TAP shall adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup (<https://www.coveroregon.com/docs/HB-2118-Recommendations.pdf>) or future consensus document, which aligns measures across major public and private payers, including commonly defined measures in each of the following domains and stratified by major subpopulations: a) access, b) quality, c) patient experience, d) patient activation, e) service utilization, and f) cost. These performance measures shall be reported to the appropriate state agency or entity, including where applicable to the All Payer All Claims (APAC) Reporting Program.

- iii. TPA health informatics. The TPA shall perform analysis of claims and clinical data to identify a) population characteristics, b) variations in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients at risk for future high-intensity service use. The TPA shall:
 - 1. measure performance across all provider types and providers with meaningful volume for the TPA's book of business.
 - 2. .
 - 3. apply clinical risk adjustment techniques when measuring provider performance and utilize socio-economic risk-adjustment techniques to the extent available.
 - 4. at request of Employer, provide monthly data files for analysis by Employer
- iv. Network Provider informatics. The TPA shall require contracted providers operating under population-based contracts to:
 - 1. perform analysis of integrated claim and clinical data to identify a) population characteristics, b) variation in care delivery, costs and avoidable complications, c) provider deviation from practice guidelines and/or clinical pathways, d) patients in need of evidence-based services, e) patients at high risk of future high-intensity service use.
 - 2. measure performance at the clinician, practice team and/or practice site, and organizational levels.

VI. Payment Strategies³

The TPA shall develop payment strategies and implement payment models that reward quality and efficiency rather than volume of services provided. The TPA shall consider implementing alternative payment methodologies such as population-based payment, episode-based payment, and payment incentives for high quality and/or improved quality and lowered cost growth. The TPA shall increase the use of systems of alternative payment models over the course of the Contract and shall report to Employer on its progress on an annual basis. By the end of Contract Year 3, 50% of TPA's payments shall be made through alternative payment methodologies. Savings distributions to contracted providers shall be contingent on quality performance. The TPA may include, but is not limited to, the following payment strategies:

³ Note: We recognize that many employers may not be ready to include the language in the Model Contract regarding payment strategies. These strategies have shown positive results in improving health outcomes and reducing costs. However, they are optional strategies that the employer can decide to phase in at a later date.

- a. **Population-based Contracts.** The TPA shall take such actions as are necessary to annually increase the proportion of providers agreeing to participate in population-based contracts.
- i. Any Population-based Contracts shall be risk adjusted, and shall not place participating providers at undo risk which may threaten solvency
 - ii. Prior to entering into a Population-based Contract, the TPA shall conduct a readiness assessment to confirm that participating providers have necessary infrastructure to administer Population-based Contracts, including:
 1. a contracted network of providers
 2. an appropriate governance structure
 3. clinical leadership
 4. care management capacity
 5. health information analysis and reporting capacity
 - iii. In order to share in any savings, Network Providers must meet quality benchmarks.
 - iv. *Additional optional measures for inclusion:*
 1. *By the end of Contract Year 3, claims for at least 60 percent of Participant lives shall be covered under a population-based contract with shared savings, and claims for at least 20 percent of insured covered lives shall be paid under a population-based contract with risk sharing. (Aggressive)*
 2. *By the end of Contract Year 3, claims for at least 45 percent of Participant lives shall be covered under a population-based contract with shared savings, and claims for at least 10 percent of insured covered lives shall be paid under a population-based contract with risk sharing. (Moderate)*
 3. *By the end of Contract Year 3, claims for at least 30 percent of Participant lives shall be covered under a population-based contract with shared savings or with risk sharing. (Easiest)*
- b. **Episode-based Payments.** The TPA shall evaluate and consider whether to implement episode-based payment strategies designed to bundle a set of services together that are related to a defined condition or treatment. Optional language to expand the focus on episode-based payments include:
- i. The TPA shall design and implement an episode-based payment strategy designed which bundles all services related to knee replacement surgery.

- ii. The TPA shall design and implement an episode-based payment strategy designed which bundles all services related to maternity care, including pre-natal care, birth and post-natal care for 6 weeks following the birth.
- c. **Pay for Performance.** The TPA shall design and implement a Pay for Performance strategy for providers that are not able or ready to participate in other alternative payment methodologies.
 - i. The TPA shall select certain measures as described in Section V above.
 - ii. The TPA shall determine baseline measurement, appropriate benchmark and improvement targets, and incentive payments linked to each measure.
 - iii. *The TPA may withhold a portion of a provider's fee-for-service payment over the course of the year to fund the Pay for Performance program. (Optional)*
- d. **Strategies designed to reduce waste.** The TPA shall design and implement payment and coverage approaches that cut waste while not diminishing quality, including reducing unwarranted payment variation. In evaluating strategies to reduce waste, the TPA should consider the following strategies at a minimum:
 - i. reference pricing,
 - ii. non-payment for avoidable complications and hospital-acquired infections,
 - iii. lower payment for non-indicated services and
 - iv. warranties on discharges for patients who undergo procedures.
- e. **Strategies designed to support primary care.** The TPA shall support PCPCH transformation and operation, ensuring that the level and method of compensation support an effective primary care infrastructure, through the use of enhanced fee schedules, supplemental payments and/or primary care capitation.

VII. Health Information Technology (HIT)

- a. **Use of Electronic Health Records (EHRs).** The TPA shall work with its provider network to increase the adoption and use of certified EHRs.
 - i. The TPA shall require physician requirements to adopt and fully utilize certified EHRs across care settings.
 - 1. Such providers shall further be required to implement systems to ensure data completeness and accuracy.
 - ii. *The TPA shall require all contracted providers, beyond physicians, to adopt and fully utilize certified EHRs. (Optional – Very Aggressive)*
 - iii. The TPA shall provide secure access to Participants to their clinical health records electronically, through a patient portal or other vehicle.

1. Such access can be provided through the TPA or the Participant's provider.
 2. Participants shall have the capacity to share information electronically with their providers.
- b. Sharing information through Health Information Exchange (HIE).** The TPA shall encourage physician and hospital providers within its provider network to use real-time electronic clinical information exchange across all care settings.
Alternative language for more aggressive implementation follows.
- i. *The TPA shall require contracted physician and hospital providers to use real-time electronic clinical information exchange across care settings. (Aggressive)*
 - ii. *The TPA shall require all contracted providers to use real-time electronic clinical information exchange across care settings. (Very Aggressive)*

VIII. Transparency

The TPA shall make accurate and understandable data on cost and quality readily available to Employer, Network Providers and Participants.

- a. **Full disclosure of provider quality performance to allow comparison.** The TPA shall develop and implement a strategy to report the comparative performance of Network Providers.
 - i. The TPA shall use the measurement set described in Section V.
 - ii. The TPA shall compare providers to state, regional and/or national benchmarks
 1. Reported differences should be statistically significant
 2. Measures for providers with insufficient denominators should not be reported.
 - iii. The TPA shall make its findings easily accessible and meaningful to Participants.
 1. Information shared shall reflect a diverse array of provider clinical attributes and activities, including but not limited to:
 - a. Provider background
 - b. Quality performance
 - c. Patient experience
 - d. Volume
 2. Information shall be explained in clear terms at a 6th grade-reading level.

- b. **Full disclosure of price per provider per services to allow comparison.** The TPA shall make specific provider price information transparent to the Employer and Participants.
 - i. Price transparency shall cover services representing at least 80% of the TPA's medical spend in all markets.
 - ii. Disclosed information shall be based on the contracted price of specific procedures and services.
 - iii. Price shall be provided in a manner that provides Participants with detailed information to understand the total price of the service, including Participant cost-sharing.

IX. Contractor Performance

This section of the Contract details the Employer's financial performance expectations of the TPA under the Contract.

- a. **Overall sustainable rate of growth.** The TPA shall work to aggressively bend the health care cost curve, while ensuring Participants receive high quality care.
 - i. The TPA shall limit annual rate of growth in its Network Provider contracts to the Consumer Price Index (CPI).
 - ii. Within population-based contracts with Network Providers, the TPA shall include a provision that the risk-adjusted annual increase in the total cost of care for services reimbursed under the Contract shall be CPI plus 1%.
- b. **Performance guarantees.** The TPA shall meet the performance and reporting requirements within this Contract.
 - i. Failure to meet these requirements shall result in a corrective action plan and potential reduction or forfeiture of the portion of the TPA's administrative fee. .
 - 1. The TPA shall also be at risk for not meeting basic administrative tasks, including but not limited to paying claims accurately and in a timely manner.
 - 2. The total amount at risk shall be equal to 5% of total health care payment made through the Contract.
 - ii. TPA shall be eligible for a performance bonus for improved quality and reduced costs. The maximum performance bonus shall be equal to the 5% of the total health care payment made through the Contract.
 - 1. Bonuses shall only be paid if the TPA's cost and quality performance comes in below (better than) the targeted amount.

Appendix A: Covered Services and Plan Design

[Note: This appendix will provide options for the Covered Services and the Plan Design that the Employer would determine it is going to offer through the TPA. The TPA is then charged with implementing the Plan. Covered Services are the benefits offered through the plan – including traditional medical services. At a minimum they must meet the essential health benefits requirements in the ACA, although large employers typically offer richer benefit packages. Plan Design focuses on cost-sharing parameters. For example, it may include having certain services at no cost-sharing to the Participant to encourage obtaining the service (preventive screenings and well-visits, no co-pays for certain maintenance drugs for chronic conditions).]

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Proposed Oregon Business Plan Health Vision-- 2020

By 2020, the citizens of Oregon and our communities will be the healthiest in the nation because we all view our health and well being as a core value, embracing healthy lifestyles and committing personal and common resources to that end.

Oregon will have an efficient and financially sustainable health care system that supports the health of all Oregonians and delivers high quality health care at an affordable price.

In turn, the Oregon business climate is enhanced and more competitive because Oregonians are healthier, employees are more productive, and the overall per capita cost of health care is one of the lowest in the nation and increasing at a financially sustainable rate.

Proposed Goals to Reach our Vision

- 1) Affordable insurance coverage for all Oregonians.
- 2) A healthy, competitive market where everyone is motivated to improve health, deliver quality, and controls costs.
- 3) All Oregonians have access to high quality, coordinated care when they need it that supports their physical health, as well as mental health and social well-being.
- 4) Consumers have the right tools and information to make the best decisions for their health and health care. Employers, providers, and insurers will have the right data to make educated purchasing, clinical, and coverage decisions
- 5) Oregon's communities work together to embrace healthy lifestyles.
- 6) Oregon's businesses provide leadership in health reform, collaborating on initiatives and advocating for policies and funding that support and further these goals.

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Goal 1. Affordable insurance coverage for all Oregonians.

Oregon Business Plan Strategies	Oregon's Progress	Oregon's Challenges	2016-2020 Priorities?
<p>Require individuals to have health care coverage.</p> <p>Subsidize private insurance for low-income workers and individuals</p> <p>Expand access to care through Medicaid expansion to reduce cost-shift to private employers.</p> <p>Establish a sustainable funding source for Medicaid that grows at a predictable rate.</p> <p>Create a public exchange to allow a one stop shopping for health insurance.</p>	<p>Hospitals, insurers, the state worked together to implement various taxes to sustain the Oregon Health Plan and expand coverage to children.</p> <p>With funding under federal health reform, approximately 440,000 Oregonians enrolled in coverage through Medicaid or Cover Oregon.</p> <p>Federal health reform created tax credits to make coverage more affordable and modified insurance rules to reduce previous barriers to coverage (e.g., pre-existing coverage exclusions)</p> <p>Oregon's rate of uninsured has gone from 14.5 % to 5.6%.</p> <p>Additionally, Medicaid's new Coordinated Care Organizations are continuing to hold down costs within the budget commitments to the federal government.</p>	<p>Health insurance exchange is in transition, with the closing of Cover Oregon and moving functions to the Oregon Insurance Division.</p> <p>Individual market rates increased substantially this year. Full impact of ACA not clear.</p> <p>State structural budget deficit beginning in 2015 when federal funding for the new Medicaid enrollees begins to decline (Est. shortfall \$2 billion in 15-17, \$5 billion in 17-19).</p>	<p>Get the Exchange running effectively for Oregonians and small business</p> <p>Develop sustainable funding approaches to address short and long term state funding concerns (reduction of federal Medicaid funding beginning in 2015-2017).</p> <p>Evaluate reform implementation and identify areas for possible policy change that could improve the effectiveness of expansions and the exchange (e.g. churning)</p> <p>Ensure sustainable growth and structure in both the individual and group insurance markets.</p>

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Goal 2. A competitive market where everyone is motivated to improve health, deliver quality, and controls costs.

Oregon Business Plan Strategies	Oregon’s Progress	Oregon’s Challenges	2016-2020 Priorities?
<p>Offer value-based, evidence-based benefit designs that require cost sharing at the time of service while avoiding financial barriers for preventive services and chronic diseases management.</p> <p>Implement new payment mechanisms that support improved quality and lower costs such as medical home models.</p> <p>Support legislation that allows the Oregon Health Plan to implement purchasing strategies used by private employers (e.g., use of a preferred drug list, integration of mental and physical health).</p> <p>Encourage employers to use a defined contribution strategy to fund employee health benefits, while providing a choice of health plans, provider networks, and benefit levels to better engage consumers and create the right market incentives.</p>	<p>Implementation of value based benefit plan by Oregon’s Public Employee Benefit Board (PEBB), MODA Health Plan, and Evraz Steel (nationally) among others.</p> <p>Focused initiatives implemented to address specific cost and quality concerns including:</p> <ul style="list-style-type: none"> • 35 of Oregon’s 53 birthing hospitals have adopted a “hard stop” policy on early elective, non medically necessary deliveries before 39 weeks gestation. • Seven health plans participated in a pilot to allow direct access to 250 physical therapists for patients with uncomplicated, acute low back pain. <p>The Oregon Health Leadership Council, insurers, providers, and the Oregon Health Authority have worked successfully to have successfully worked to:</p> <ul style="list-style-type: none"> • increase the use of websites for eligibility and claims 	<p>Provide tools to employers to 1) assess if private or public exchanges are/can be a more effective channel to offer benefits and better align incentives, and 2) tools to incorporate these strategies</p> <p>Oregon does not have a true small employer health insurance exchange. Still needed? Or are private exchanges filling the need?</p>	<p>Articulate next steps and goals for the Oregon’s health insurance exchange, particularly development of a small employer market place.</p> <p>Help determine the best channel that could work for employers— public or private exchanges, self-insurance or insurance</p> <p>Continually identify and develop approaches for managing cost drivers (e.g., pharmaceutical cost growth, high utilization of emergency rooms, inappropriate opiate usage)</p>

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<p>Support public and private exchanges to provide these options to consumers and small businesses.</p> <p>Simplify the administrative challenges faced by physicians and other healthcare professionals to increase efficiency and provide cost-savings to the entire system.</p>	<p>information (OneHealthPort),</p> <ul style="list-style-type: none"> • increase the use of electronic transactions, • improve prior authorization processes and; • work toward standardization and automation of key processes. 		
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Goal 3. All Oregonians have access to high quality, coordinated care when they need it that supports their physical health, as well as mental health and social well-being.

Oregon Business Plan Strategies	Oregon’s Progress	Oregon’s Challenges	2016-2020 Priorities?
<p>Health care payers, health plans and self-insured employers implement medical home and other innovative approaches that support integrated care, increase quality, and reduced unnecessary services.</p> <p>Ensure access to providers for Oregon Health Plan patients by increasing provider payments and reduce the cost shift to privately-insured patients.</p>	<p>Extensive work on medical home implementation with early OHLC/insurer demonstration on high value medical home (2009-11). The Oregon Health Authority (OHA) with broad collaboration created the Patient Centered Primary Care Home program. By the end of 2014, 538 clinics were certified as medical homes, representing 50% of the eligible clinics and over half of the state’s population.</p>	<p>CCOs are not fully implemented. Further integration of mental health, addiction, and dental health services still needed.</p> <p>Continued access concerns for Medicaid enrollees, rural, and traditionally underserved residents overall.</p>	<p>Assess the efficacy and financial sustainability of delivery system reforms (e.g., medical home for everyone)</p> <p>Full implementation of CCO model (mental health, addiction, dental services) and continued Continue focus on outcome metrics and staying within budget</p> <p>New models of care for</p>

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<p>Support the implementation of OHP Coordinated Care Organizations.</p>	<p>Implementation of the coordinated care model through Medicaid Coordinated Care Organizations (CCOs) and PEBB state employee coverage.</p> <p>Implementation of an advanced set of CCO performance metrics tied to incentive pool payments. Early indicators point to decreased emergency room visits and increased primary care visits.</p>		<p>complicated social/medical concerns</p> <ul style="list-style-type: none"> • Expand and create new innovative mental health and addiction service models • Expand use of non-medical models to address a full range of complicated social, environmental, and other factors that lead to health disparities among Oregonians • Align outcome metrics that encompass social, environmental, and economic concerns (e.g., affordable housing, living wage jobs) <p>Increased health care workforce capacity</p> <ul style="list-style-type: none"> • Improve primary care physician and physician extender capacity to improve care access, reduce ER utilization, and avoid provider burnout. • Ensure broad provider acceptance to see Medicaid enrollees to ensure access to patients and reduce waiting lists
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Goal 4. Consumers have the right tools and information to make the best decisions for their health and health care and employers, providers and insurers have the right data to make educated purchasing, clinical and coverage decisions.

Oregon Business Plan Strategies	Oregon’s Progress	Oregon’s Challenges	2016-2020 Priorities?
<p>Develop the capacity to have meaningful information on costs and quality readily available to consumers, purchasers and providers.</p> <p>Implement evidence-based tools that are simple, understandable and can be used by consumers to improve decision making on health plans, providers, locations of services and treatment options.</p> <p>Deploy strategies to improve health literacy and support more informed decision making (e.g. Advance Care Planning, Palliative care)</p> <p>Establish a standard data set that payers use to measure and pay for performance and outcomes</p> <p>Continue efforts to improve health care information infrastructure: electronic health records, secure exchange of health data among providers, transparent information on costs and quality, and standardized quality measures.</p>	<p>Implementation in all of Oregon’s hospitals of technology (EDIE/ PreManage) that allows clinicians to identify patients who visit the emergency rooms who would be best served in another setting of care, as well as share data with health plans, CCOs, and provider groups to enable timely and informed care coordination and population management.</p> <p>Many efforts to make meaningful quality data available across physicians, hospitals, and insurers. The Oregon Health Care Quality Corporation has been actively producing quality measurement reports since 2007, aggregating data across participating health plans.</p>	<p>Dashboards and quality metrics are not fully aligned across public and private payers.</p> <p>Transparent health care cost data still very difficult to obtain and use in many cases.</p> <p>A sustainable model for cost and quality reporting is still needed.</p>	<p>Data transparency, analysis, and exchange</p> <ul style="list-style-type: none"> • Continue expansion of electronic health records and electronic information exchange • Truly align outcome metrics and dashboards across stakeholders • Continued focus on technology development for better care delivery <p>Develop a model for collaborative and impartial cost and quality reporting that can be sustained and adequately involves necessary stakeholders.</p>

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Goal 5. Communities work together to embrace healthy lifestyles.

Oregon Business Plan Strategies	Oregon's Progress	Oregon's Challenges	2016-2020 Priorities?
<p>Support educational efforts to define the roles of Oregonians in their role in their health and well-being of their communities.</p> <p>Develop and implement the Healthiest State Initiative.</p>	<p><Table under development></p>		<p>Improved consumer engagement and focus on population wellness</p> <ul style="list-style-type: none"> • Continue focus on improving consumer understanding and engagement in their own health, including health care service decisions and insurance coverage options. • Better integrate and support of health care and population health approaches to prevent and better manage disease. <p>Continue implementation of the Healthiest State Initiative:</p> <ul style="list-style-type: none"> • Identify the issues that, if reversed, would have the greatest impact and mobilize allies working in these areas, agree to common indicators of progress, and drive a common agenda. • Provide resources, tools, and support for local communities to transform their infrastructure, practices and policies to ensure that healthy options are abundant

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Goal 6: Oregon’s businesses serve as leaders in reform, collaborating on initiatives and advocating for policies and funding that support and further these goals.

Oregon Business Plan Strategies	Oregon’s Progress	Oregon’s Challenges?	2016-2020 Priorities?
<p>Improve understanding of the implications of federal and state health reform on business and the overall state economy, including the funding costs for Medicaid and its effect on other funding priorities (e.g., education, transportation).</p> <p>Encourage a culture of wellness and personal responsibility in the workplace; offer and include incentives for participation in health and wellness programs.</p> <p>Private and public employers drive reform through their benefit offerings to create greater aligned incentives among consumers, providers and payers to achieve these goals (e.g., value based benefit design, increase the use of defined contribution for employee insurance, providing a choice of health plan packages.)</p> <p>Advocate for other policies that support the Oregon Business Plan health and health care goals.</p> <p>Create a forum and collaborate with other organizations to align and motivate health reform efforts going forward.</p>	<p>Employers involved in significant policy development through the Oregon Health Fund Board, the Oregon Health Policy Board, and numerous committees.</p> <p>Successful collective support and advocacy to create funding strategies for the Oregon Health Plan during periods of economic recession.</p> <p>Established the Oregon Health Leadership Council to champion collaborative reform efforts across employers, insurers, providers, and the state.</p> <p>Numerous examples of private and public employers (e.g., PEBB) implementing workplace health and wellness programs.</p>	<p>Continue a shared reform vision and strategic framework to focus collaboration and keep pressure on initiatives.</p> <p>Strive for an even representation of employers along with providers, insurers, advocates, and policymakers in discussions to balance objectives.</p>	<p>Maintain collaborative tables such as the Oregon Health Leadership Council and expand the representation of non-health care perspectives at these venues.</p> <p>Build leadership across all business sectors to champion collaborative reform efforts.</p>

Fall 2015 Oregon Business Plan Health Care Strategy Reset

Outcome

Build consensus among Oregon's business community around a refreshed set of health care strategies for the Oregon Business Plan that builds off the state's successes of the last decade and provides direction to collaborative reform work moving forward.

Planning Goals

- Provide a clear and useful discussion document on the current state of health care reform in Oregon. What have we accomplished and where are there still significant challenges?
- Articulate an Oregon Business Plan strategic framework for the next 6-8 years that capitalizes on past reforms. Where do we focus public and private resources going forward?
- Create an updated white paper on OBP framework and related presentations that are useful for policymakers and business leaders to build momentum and facilitate initiatives.

Timeline

In Fall 2015, we will hold facilitated discussions with a variety of stakeholder groups to gather input and perspective. We will also conduct a brief informal survey of business leaders to gauge reform involvement and interest. We will present our initial findings at the October Roundtable and, based on additional feedback, will finalize a white paper by the end of December. A presentation and other reference documents for use by OBC, OHLC, and other business representatives will be distributed in early January 2016.

Proposed Facilitated Discussion Questions

- Which of Oregon's health reform successes over the last decade have made the most progress towards improving cost, quality and access?
- What remains to be Oregon's biggest challenges in health and health care?
- What questions do you have about where the state, insurers, providers have been headed so far? Where do you need more clarity?
- What are your biggest concerns about the reform efforts of the last decade?
- What type of data is the most compelling to motivate change?
- Does the proposed OBP health care vision resonate?
- What are the major goals that should receive focused common attention across business, providers, insurers, and the state over the next five years?
 - What are the most important short term goals? Long term?
 - What strategies would support those goals?
- What do you see as your organization's role in reform?

Proposed Stakeholder Groups

- State/policymakers
- Health plans
- Providers
- Employers

Proposed Topics for Business, Insurer, Provider Community Survey

- Their understanding and support of the Oregon Business Plan strategies to date.
- Implementation of OBP health care strategies (e.g., defined contribution with choice of plans).
- Their interest and ideas for engaging in reform efforts going forward.