

Coordinated Care Model Alignment Workgroup Toolkit

Background

The Oregon Health Policy Board charged the Coordinated Care Model Alignment Workgroup with spreading the Coordinated Care Model (CCM) to the commercial market. The Workgroup was charged with developing a host of tools that will assist in the implementation of CCM principles across multiple market segments.

Coordinated Care Model Alignment Efforts among Carriers and Purchasers: Environmental Scan Report

The scan aims to develop a more comprehensive picture of Oregon's health insurance market and existing programmatic and operational efforts to adopt the CCM. The Oregon Health Authority, with support from Bailit Health Purchasing, interviewed carriers and purchasers throughout the state. The information helped the CCMA workgroup define tools that might be helpful to purchasers and carriers thinking about adoption of the CCM components and for consumers seeking to understand the model.

Toolkit

After conducting an environmental scan of carriers and purchasers, the Coordinated Care Model Alignment Workgroup identified tools that would be helpful to those thinking of adopting CCM components. The toolkit is intended to assist purchasers, carriers, and consumers in developing an understanding of each element of the CCM and provides resources and tools to assist in the adoption and implementation of the CCM. The toolkit components include the following items:

- **Oregon's Coordinated Care Model**
The communications tool describes the Coordinated Care Model and its importance to purchasers, employees and carriers.
- **Operationalizing the Principles of Oregon's Coordinated Care Model: A High-Level Framework for Procurement and Contracting**
The Framework for Procurement and Contracting is designed to be used by purchasers for self-insured products but can also be used for fully-insured plans. The document serves as a roadmap for purchasers looking to incorporate the CCM components into their benefits purchasing. The framework focuses on concepts tied to the CCM principles and identifies operational elements at the plan and provider level to form an applied set of strategies to transform care delivery. The framework highlights the critical elements of the model and offers specific measures or targets that could be adopted to encourage progress towards transformation of specific areas (e.g., PCPCH, team-based care, Alternative Payment Methodologies).

- **Model Contract**

The purpose of the Model Contract is to assist self-funded employers in implementing CCM elements through an agreement with a Third Party Administrator (TPA). Most of the model contract language could also be used by fully-insured employers in agreements with health insurers and by multi-state employers. The concepts of the CCM are not unique to Oregon and are being implemented nationally by employers. The model contract does not include language on standard administrative services and employers will have to work with their TPA to ensure that the information is incorporated since it would be required in a contract. The model contract assumes that these employers have a comprehensive benefit package that exceeds what is in Essential Health Benefits and doesn't provide details on what would be included. 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.

- **Fact sheets: Payment Reform Matters, Multi-state Employers Should Participate in Payment Reform, and Patient-Centered Primary Care Homes (PCPCH)**

To assist purchasers and carriers in understanding specific concepts of the CCM, the Workgroup developed three fact sheets to describe the importance of adopting and implementing key pieces of the CCM, including payment reform and PCPCHs, to achieve transformation that results in better care, better health and lower costs.

- **Checklist: Finding a Coordinated Care Health Plan for Your Employees**

The checklist is intended for employers seeking to incorporate elements of the CCM into their existing or future plan for their employees. When speaking to a broker or carrier, the purchaser can use it as a guide to inform the benefits purchasing process.

Under the State Innovation Model Grant, the communications team has contracted with a vendor (Metropolitan Group) that will develop additional messaging and communication strategies for specific groups, including brokers and employers. Once this work is completed, the products will be added into the toolkit.

Oregon Health Authority and Oregon Health Policy Board

Coordinated Care Model Alignment Efforts Among Carriers and Purchasers

Environmental Scan Report

Coordinated Care Model Alignment Workgroup
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Executive Summary

The Oregon Health Policy Board has charged the Coordinated Care Model Alignment (CCMA) Workgroup with spreading the Coordinated Care Model (CCM) to the commercial market. The Workgroup is charged with developing a host of tools that will assist in the implementation of CCM principles across multiple market segments, including a toolkit for purchasers. In addition, the CCMA Workgroup is sponsoring the environmental scan effort described in this report.

The environmental scan aims to develop a more comprehensive picture of Oregon's health insurance market and existing programmatic and operational efforts to adopt the CCM. The scan aims to develop a more robust understanding of the challenges, needs, and the resources available to facilitate the spread of the CCM. The Oregon Health Authority, with support from Bailit Health Purchasing, interviewed carriers and purchasers throughout the state. Developing an understanding of the various market segments and their underlying concerns and motivations will aid the Oregon Health Authority in the creation of a messaging and communications framework that describes the model and the benefits to the consumer, carrier, and purchaser. Additionally, the information will help the CCMA workgroup define other tools that might be helpful to purchasers and carriers thinking about adoption of the CCM components and for consumers seeking to understand the model.

The CCMA workgroup gained several insights from the interviews that will aid CCM spread efforts:

- Continued education about the Coordinated Care Model is critical.
- Collaboration and continued engagement between carriers, purchasers, and the Oregon Health Authority is necessary.
- Multi-payer payment reform is critical to support innovations in the care delivery model.
- The Oregon Health Authority and the CCMA workgroup should provide resources and support to purchasers and carriers as they determine the degree to which their infrastructure can support adoption of the CCM.

Continued education about the CCM is critical. Though many carriers and purchasers are aware of the CCM, those not involved as Coordinated Care Organizations (CCOs) typically have limited knowledge about the benefits of the model and the applicability of the model to their particular population. Several entities expressed a difficulty in translating particular pieces of the CCM to the commercial market. For example, several carriers and purchasers are unsure about the applicability of social determinants of health to the commercial market population because this population is typically higher income, in comparison to the Medicaid population.

Going forward it will be imperative to compile and communicate the evidence supporting the value (return on investment) of the model and its individual components to carriers, purchasers, and employees. Each of these groups will play a unique role in supporting the spread of the CCM. It will also be helpful to build awareness about the CCM among brokers and consultants because they often assist purchasers in designing benefits and selecting plan offerings, and will be essential to communicating the value of the CCM to employers.

Collaboration and continued engagement between carriers, purchasers, and the Oregon Health Authority is necessary. Though several carriers and purchasers have started to align with the CCM, there are limited opportunities to share lessons learned and successes implementing specific pieces of the model. As the CCM

spreads, the state, carriers and purchasers should collaborate to address challenges and barriers to the model's adoption. Now, carriers and purchasers are operating in silos attempting to understand and translate the model to their commercial environment and purchasing needs.

Several carriers and purchasers have started to adapt pieces of the CCM to the commercial market (e.g., behavioral health integration), and it would be helpful to share findings broadly across carriers and purchasers. The Oregon Health Authority has started to convene various organizations working on advancing the CCM. For example, in Fall 2013, almost all of Oregon's major public and private payers signed an agreement to support alternative payment strategies for Patient-Centered Primary Care Homes (PCPCHs) across the state. Additionally, the Transformation Center provides significant supports to CCOs through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. Four learning collaboratives are underway and focus on incentive pool metrics, provider approaches to complex care, and engaging CCOs' community advisory councils. Though this work has largely centered on CCOs, the state may have a role in convening future groups to foster learning and engagement across commercial entities working towards the same goal – implementation of the CCM.

Multi-payer payment reform is critical to support innovations in the care delivery model. Consistent with Oregon's CCM, there is a growing movement nationwide towards outcomes-based payment and away from a volume-based fee-for-service system. Payment for care should be based on quality and health outcomes rather than on volume of services provided. Carriers and purchasers agreed that to support better care and minimize cost growth, private- and public-sector payers should adopt alternative payment methodologies such as population-based payment (global payment), episode-based payment, and incentives for performance and quality outcomes. To slow the growth in overall health care system costs, it will be critical for commercial health insurance carriers to adopt payment innovations that shift provider and consumer behavior. However, carriers note that they do not always have enough market share on their own to implement these reforms.

Provide resources and support to purchasers as they determine the degree to which their infrastructure can support adoption of the CCM. Due to a lack of or limited infrastructure, several purchasers mentioned that state assistance is crucial to engender support of specific pieces of the CCM (e.g., alternative payment methodologies, behavioral health integration). Adoption of these particular components will likely occur more slowly without state support. The state should continue to develop resources and tools to assist purchasers in adopting the CCM and to improve overall understanding of the individual components of the model, such as toolkit for purchasers that the CCMA has begun to develop.

Background

What is the Coordinated Care Model?

Oregon’s CCM consists of six principles (see figure 1) that improve the quality and value of health care for individuals. Though the key elements can be adopted separately, they are most effective in achieving better health, better care and lower costs when used together. The six principles, as explained below, have been adopted by CCOs serving the Medicaid population.

- Using best practices to manage and coordinate care: The model is built on the use of evidence-based best practices to manage and coordinate care (e.g., value-based benefit design, patient-centered primary care homes). These best practices produce better care, improved outcomes (including a positive patient experience) and lower costs.
- Shared responsibility for health: When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and consumers can share responsibility and decision-making for care, while coming to joint agreements on how the individual wants to improve or maintain positive health behaviors.
- Transparency in price and quality: Cost and quality data that is readily available, reliable and clear helps patients understand their health plan and provider choices and it helps purchasers make decisions about choosing health plans. With access to data, patients can share responsibility in their health care decisions. Increased transparency on price and quality can also lead to increased accountability.
- Measure performance: Performance measurement that is consistent across health systems improves opportunities, performance, and accountability, while easing providers’ reporting burden. It may also help improve the quality of care in the health system as a whole.
- Pay for outcomes and health: Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. Innovative payment methods such as population and episode-based payments, and offering incentives for quality outcomes instead of volume-based fees support better care and lower costs.
- Sustainable rate of growth: Bending the cost curve is a vital component of the coordinated care model – and one that strengthens all other principles. Preventing a cost shift to employers, individuals, and families, and reducing inappropriate use and costs through a fixed-rate-of-growth approach is the foundation to health care transformation.



Figure 1

Spreading the Coordinated Care Model

Over time, the state hopes to incorporate the CCM principles used by the CCOs into all lines of business in the commercial market, including the Public Employees’ Benefit Board (PEBB), the Oregon Educators’ Benefit Board (OEBC), the health insurance marketplace, and the broader market. Adoption of the model principles across the commercial market will ensure that all Oregonians have access to coordinated and patient-centered care, lower out of pocket costs, and improved health outcomes.

To date, sixteen CCOs are up and operating, serving over 90% of Oregon Health Plan members. Recent data as of January 2015 show that of the approximate 71,450 duals in Oregon, 58% are enrolled in CCOs¹ by choice (not mandated to enroll) and receiving care based on the Coordinated Care Model. Many of the CCOs have affiliated Medicare Advantage plans, which has aided in duals engagement. Performance indicators show that CCOs have achieved the following preliminary outcomes: increase in primary care use and spending; decrease in inpatient stays due to chronic illness; and decrease in emergency department utilization and costs.²

The state is making large investments into the health care system and care delivery through the implementation of the CCOs. To ensure the CCM is sustainable, it must be ingrained into how care is delivered across Oregon. Given early results showing improved outcomes through implementation of the CCOs, the state currently is working to spread the CCM to other state purchasers, including PEBB and OEGB. In 2015 contracts with eight health plans, PEBB required the plans to include CCM elements in their health benefit offerings. The forthcoming OEGB Request for Proposals aims to: 1) expand the CCM based health plan offerings and availability in Oregon counties; and 2) contract with health plan partners committed to transforming Oregon's healthcare system to achieve the Triple Aim for OEGB members and Oregonians.

If the model does not spread to remaining portion of the commercial market, cost reductions in Medicaid could lead to cost increases for private payers, including insurers and self-insured employers, eventually shifting costs to the individual. It is critical that Oregon begin to bend the cost curve to ensure long-term cost savings and predictability for health insurers, employers, and individuals. Because the commercial and Medicaid markets are considerably different (e.g., market cultures, consumer expectations), it will be critical to provide the private sector with incontrovertible evidence that the CCM will improve outcomes and reduce costs over time.

Understanding the Current Landscape

The degree and pace of CCM adoption will be impacted by differences between insured populations and unique market characteristics. Due to these variances, some market segments might have increased interest in specific pieces of the model or may select to phase-in certain elements of the model over time. To understand the opportunities for alignment across market segments, Appendix A provides a comparison of covered populations and plan design across different markets in Oregon. The findings from the environmental scan and Appendix A will help enhance our understanding of potential points of convergence across Oregon's market segments.

To begin to understand the current health insurance market landscape in Oregon, the Office of Health Policy and Research (OHPR) and Bailit Health Purchasing conducted interviews with eleven commercial carriers³ and seven large employers⁴ to understand their interest and readiness to adopt the Coordinated Care Model. Twelve carriers and eleven purchasers received an invitation for an interview. Carriers selected for an interview

¹ Oregon Health Plan, OHP Data and Reports. "Enrollment report: January 2015 Medicare-Medicaid Enrollment." January 15, 2015. Available at: <http://www.oregon.gov/oha/healthplan/pages/reports.aspx>.

² Oregon Health Authority, Office of Health Analytics, "Oregon's Health System Transformation 2014 Mid-Year Report," January 2015. Available at: <http://www.oregon.gov/oha/metrics/Pages/index.aspx>

³ Interviewed insurers included Kaiser Permanente, Lifewise, Moda, PacificSource, Providence, Regence Blue Cross Blue Shield, Trillium, Aetna, Cigna, Health Net Health Plan, and UnitedHealthCare.

⁴ Interviewed employers included Springfield School District, Trimet, Pape Group, Jeld-Wen, Peace Health, OHSU, and Multnomah County.

participated in three or more market segments (e.g., small group, large group, Medicaid) and had a significant share of covered lives in Oregon. Interviewed carriers represent all of the largest insurers in the state. Purchasers selected for an interview were identified through a series of discussions with the Oregon Insurance Division and Coordinated Care Model Alignment Workgroup members. Interviewed purchasers only included large group employers and did not include small group employers, making the report's findings less representative of all Oregon purchasers.

The State aimed to obtain several pieces of information from carriers and purchasers:

- Interest and readiness to adopt elements of the Coordinated Care Model;
- Programmatic and operational efforts supporting the Coordinated Care Model;
- Provider (hospital and physician) interest and readiness (carriers only);
- Challenges/barriers to Coordinated Care Model spread;
- Needs of the market segment affecting the ability to spread the model; and
- Available resources to facilitate the adoption of the model.

Interviewers used standardized questionnaires for each group. Appendices B and C contain the interview questionnaires used for health insurance carriers and purchasers, respectively.

Themes from Carrier Interviews

There is significant interest in aligning with the Coordinated Care Model.

Most of the carriers were generally aware of the CCM and expressed interest in aligning with the model and its principles in the years to come. Many carriers have already adopted certain elements of the CCM (e.g., medical home, care coordination), and are tailoring other model components to the intricacies of the commercial landscape in Oregon. For example, a carrier has a commercial medical home network that builds specific commercial requirements on top of the Patient Centered Primary Care Home (PCPCH) program standards. As noted below, carriers are just beginning to implement payment reform in the commercial market and are interested in ensuring that there is enough alignment across the market to ensure reform works based on their own market size. Several carriers felt that only certain elements of the model are applicable to the commercial market, while others are most pertinent to the Medicaid market, but all acknowledged that they need to change how care is delivered to reduce overall health care cost growth. Carriers involved with the CCOs are generally further along in translating the model to the commercial side.

Quote: "The instinct that we should want to bring more of the CCM principles to commercial carriers makes total sense, but the commercial marketplace has some uniqueness not present in Medicaid and there is variability in demands among self-funded customers. A lot of evolution would need to happen within individual components of the CCM before we can apply it to value-based purchasing approaches on the commercial side."

There is varying progress in payment reform outside of Medicaid.

There seems to be considerable interest in paying for value and moving away from FFS and a number of carriers are piloting specific alternative payment methodologies (APM) (e.g., pay for performance, PCPCH supplemental payment, shared savings and/or risk, capitation, bundled payment) based on services or networks. Many carriers are trying to determine the appropriate payment mechanism for their line of business and population demographics, especially for those with a smaller number of covered lives. According to carriers, many providers seem to have limited interest and capacity to support payment reform. Though payment models are supposed to create shared responsibility among providers and reward improved outcomes, many carriers do not feel that there has been decisive evidence in support of any particular payment model. Those that are further along in payment reform use a variety of APMs and apply them differently to providers and networks.

Quote: "Trying to move providers from volume towards working within a budget. On the commercial side it's harder to get traction on alternative payments and attribute members to providers, so the shift is going to be slower."

Limited use of tiered or high-performing networks.

Though many carriers are capable of providing tiered network products, there is not a significant demand for these types of products, so they are not widely offered. Those that offer products with tiered networks typically tier according to cost and quality. Some of the tiered networks are specific to specialists or other narrow networks of providers. Many health plans have introduced high performing networks to encourage the use of providers that are deemed as high performing on efficiency and quality measures. However, in Oregon, few carriers offer high performing provider networks currently because most purchasers request broad networks, but there is plan interest in developing these further in the Northwest market.

Quote: "Though these products are available, there has been limited use of these networks. Many employers want broad networks and brokers have not mentioned that there is interest in these options."

Willingness to have common health outcomes and quality measure set.

The majority of domestic carriers are in support of a common, standardized performance measure set to minimize the burden and costs on providers, but many stated that the measures should be aligned with other national certification reporting requirements (e.g., NCQA and HEDIS). National carriers stated that they face some difficulty in adopting and committing to a common performance measure set because there is high variance across the states they serve. A few carriers mentioned that the measures recommended by the Health Plan Quality Measure Workgroup require additional refinement to fit the needs of the commercial market.

Quote: "The conversation about a common measure set is happening in many venues. We are interested in looking at this but we need to make sure that the common set of measure set addresses other requirements (e.g., NCQA, HEDIS) and that they are the right measures for a commercial population."

Limited focus on whole-person health, behavioral health integration or social determinants of health outside of Medicaid population.

A number of carriers are beginning to integrate behavioral health into the primary care setting, yet few have made significant progress in care integration. Though carriers recognize the importance of behavioral health and physical health integration, several are still determining how they can support integration efforts and there is some exploration in this area through grant and community benefit funding to providers and community-based organizations. For example, one carrier has collaborated with a local community health center to develop a complex care center that addresses barriers to wellness, including behavioral health issues, through targeted patient identification, specialized, team-based primary care.

Quote: "Behavioral health has to be an integral part of care delivery but we have not found the right solution to ensure that care is actually integrated. This will be a focus moving forward."

Few carriers have started to think about social determinants of health for the commercial population and a number of them stated that they do not feel social service supports are as crucial for this group. When these supports are necessary, they are addressed at the individual level through case management services. Those that have started thinking about social determinants of health are trying to understand the demographics of their population, including health risk factors, and determining how to scale targeted services to populations in commercial products. Carriers that are involved with the CCOs are further along in thinking about and incorporating social determinants of health into the benefits and services offered. For example, CCO-involved plans that provide coverage in the commercial market have a delivery system that offers established care integration and standing relationships with social agencies giving them a relative advantage in addressing social needs.

Quote: "One of the challenges is how to scale these social supports services to less risky populations when employers are focused on lower premiums."

Majority of carriers share performance reports with providers to assist them in managing their patient panels.

Most carriers are focused on sharing a variety of performance and member care reports with providers, so that they can improve quality of care, track patient health needs, and manage their panels. A number of carriers engage provider organizations in continued discussions to target improvements in areas identified as low performing within reports. Several carriers mentioned that they wanted to develop more robust reporting for providers. Carriers that share performance reports with purchasers focus on quality outcomes (e.g., HEDIS) and costs of population experience.

Quote: “We provide a suite of reports to providers (and employers) that show how a provider is doing compared to past performance and network averages of cost and quality and, for selected providers, we provide care gap reports to ensure members are receiving routine preventive services.”

Significant carrier interest in adding or strengthening telehealth capabilities.

Many carriers have telehealth programs in place and are thinking of using these programs to target services to population needs (e.g., geographic need, specialty care, urgent, primary care). Several carriers contract with national vendors to offer telehealth services to consumers. Others who do not offer telehealth services are funding provider grants to develop such capabilities and are continuing to explore the area to determine an appropriate approach.

Quote: “Telehealth is starting to expand how we deliver care, especially in remote areas. There is a lot of interest in further exploring this area to deliver these types of services effectively.”

Themes from Purchaser Interviews

High use of brokers and consultants for plan selection and benefit design.

All of the purchasers interviewed rely on brokers and/or consultants to design their benefit packages. Some employers, particularly those with union employees, have benefit councils or committees that weigh in on benefit and plan selections. Involvement with particular brokers/consultants can affect what an employer thinks they can do on their own vs. with a carrier. If an employer’s broker or consultant is engaged in delivery system reform conversations, employers are more empowered to try to move delivery system reform forward through their plan selection and benefit design. Those employers who rely on brokers that are not as engaged in delivery system reform have a limited understanding of their opportunity to push for changes in their benefit design and are more likely to purchase carrier designated offerings.

Most of the employers in this sample are self-insured or thinking of moving towards being self-insured.

Most purchasers we interviewed have recently moved to being self-insured because they believe they can achieve more cost savings. A couple of purchasers offer a mixture of fully insured and self-insured products, but they are continuing to consider other cost saving options. A couple of purchasers mentioned that they are starting to think about making changes to their benefit offerings due to the upcoming excise tax under the Affordable Care Act.

Employers provide minimal direction or do not require carriers to incorporate CCM components into plan design.

Most employers are hands-off with plan design and inclusion of innovative payment and care delivery options into plan offerings. Many are reliant on the carrier plan offerings and do not push carriers to design offerings that are tailored to their employees’ unique needs. Employers with limited buying power – those with fewer covered lives – feel that they don’t have the leverage to influence carriers to implement the CCM. One employer described that it is seeking to combine purchasing power with another employer to better be able to direct plan design.

Quote: "Many of the delivery system and payment innovations are outside of our negotiation with carriers and those generally happen in contracts between the carrier and provider."

Efforts to align with the Coordinated Care Model are limited to certain employers.

Employers that are government entities or are health care based are more focused on implementing a CCM-like model than others. Only one employer outside of these two areas has made significant efforts to incorporate model components into its plan design and develop solutions with outside contractors. Employers subject to collective bargaining may have a harder time incorporating CCM components, but many are interested in educating union representatives about the model to ensure adoption.

Quote: "We are looking to use our TPA's product that has coordinated care facets and will model a plan option around the CCM."

A number of purchasers have employees across several states limiting their ability to implement components of the CCM due to coordination challenges. Those with larger pockets of Oregon based covered lives are willing to push carriers towards adoption of certain model components.

Many recognize the need to educate themselves and their workforce about health coverage options and the CCM.

Overall, it was apparent that there is limited knowledge and awareness about the CCM among employers and education/outreach will be critical to help employers and employees understand the benefits of the model. Most employers stated that employee education would be necessary to help individuals understand their options, health benefits and the CCM. Some stated that they are looking to the state to develop educational materials for employees and employers around the CCM.

Quote: "It will be important to educate employees and the union about the CCM, so that we can start moving in that direction. We will need resources and tools that the state has developed about the model."

Employers reported that incentives are helpful to motivate and engage employees in their health.

A majority of employers offer incentives (monetary and non-monetary) to employees for healthy behaviors, use of preventive services, and/or use of evidence-based services. Many employers engage employees in wellness challenges at the workplace or offer incentives to participate in wellness activities offered through the carrier(s) or separate wellness vendors.

Quote: "Though we don't offer direct incentives, we offer employees various supports and promotions throughout the year in partnership with local community organizations, the plan, and workplace wellness programs."

Some employees have identified access to providers as an important criterion for plan selection.

A few service industry employers mentioned that there is significant interest among their employee base in maintaining a broad provider network. Employees might consider a plan option based on the CCM to be unfavorable if it is perceived as having a limited or restricted network.

Quote: "There is an interest among employees in maintaining broad access to providers, including alternative medicine such as naturopathy and massage therapy."

A handful of purchasers are starting to think about the applicability of social determinants of health to their employee base.

Though most purchasers are not focusing on social determinants of health, a few are discussing how to best address social needs through their benefit offerings given the additional health care costs associated with individuals requiring social supports. One purchaser has already implemented a health advocate program that helps employees navigate the health care system and connect them with community resources to overcome socioeconomic needs.

Quote: “We have talked about social determinants of health a lot but we have been unable to come to a consensus about how we might be able to address this issue. Everyone understands that there might be value to an individual but there are associated costs and it is difficult to determine if the employer (and the benefit plan) has the licensure to address social needs. Additionally, there are issues with the administration of benefits related to social determinants of health that would require resource tradeoffs for the employer to be able to incorporate such supports into benefit offerings. We simply do not have the infrastructure to support this effort, and it would be helpful if the state created programming (using economies of scale) to facilitate employer participation.”

Appendix A

Comparison of Oregon's Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design				
	Oregon Health Plan	Public Employees' Benefit Board (PEBB)	Oregon Educators' Benefit Board (OEBB)	Commercial
Eligible populations	<ul style="list-style-type: none"> • Non-pregnant adults ages 19-64 with income up to 138% FPL • Pregnant women ages 21 and older with income up to 185% FPL • Kids and teens (ages 0-18) with income up to 300% FPL (children's Medicaid up to 185% FPL) • Blind and disabled up to 75% FPL and those meeting the long-term care criteria up to 225% FPL 	<ul style="list-style-type: none"> • State agency employees • University employees • Lottery and semi-independent state agencies 	<ul style="list-style-type: none"> • Employees of school districts, educational service districts, community colleges and public charter schools • Employees of two counties and two special districts • Eligible to join – nine school districts, one community college, and 1,218 local governments and special districts 	<ul style="list-style-type: none"> • Small group: employees of small employers (starting in 2016 defined as 1-100 employees) • Large group: employees of large employers (starting in 2016 defined as 101 or more employees) • Individual: medical policies for Oregon subscribers and eligible dependents • Other: associations and trusts
Covered lives	As of June 2015, there are 1,050,178 members	As of March 2015, there are 132,964 subscribers and dependents	As of March 2015, there are 142,200 subscribers and dependents	As of 2014 Q2: <ul style="list-style-type: none"> • Small group – 161,948 individuals • Large group – 567,280 individuals self-insured – 777,094 individuals • Individual/direct purchase – 202,757 individuals • Associations and trusts – 108,872 individuals
Age, gender, ethnicity	<ul style="list-style-type: none"> • Age: <ul style="list-style-type: none"> – 43% are children – 40% are adults – 13% are aged • Gender: 59.8% are female 	<ul style="list-style-type: none"> • Mean age is 48.6 • Gender: 57.5% are female • Race/ethnicity: 4% are Latina/o 	<ul style="list-style-type: none"> • Mean age is 47.5 • Gender: 74.8% are female • Race/ethnicity: 4.6% are Latina/o 	<ul style="list-style-type: none"> • Age: <ul style="list-style-type: none"> – 12.7% are between 18-34 – 28.1% are between 35-54 – 25.4% are between 55-64 – 33.7% are 65 and older

Comparison of Oregon’s Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design				
	Oregon Health Plan	Public Employees’ Benefit Board (PEBB)	Oregon Educators’ Benefit Board (OEBB)	Commercial
	<ul style="list-style-type: none"> • Race/ethnicity: <ul style="list-style-type: none"> – 78.5% are white – 15.2% are Hispanic – 3.3% are American Indian/Alaska Native – 1.4% are African American – 1.8% are Asian (includes Pacific Islander) 			<ul style="list-style-type: none"> • Gender: 59% are female • Race/ethnicity: <ul style="list-style-type: none"> – 78.5% are white – 11.7% are Latina/o – 3.7% are Asian – 1.8% are African American – 1.4% are American Indian/Alaska Native
Geographic coverage	16 CCOs provide coverage in all 36 Oregon counties	All 36 Oregon counties have two or more medical plans available	Coverage in every Oregon county	Coverage limited to contracted plan service areas
Prevalence of chronic conditions/disabilities	<ul style="list-style-type: none"> • 64.7% of Medicaid BRFS (MBRFS) respondents have a chronic disease • 36.8% of MBRFS respondents are depressed • 56% of MBRFS respondents had limited activity due to poor health⁵ 	<ul style="list-style-type: none"> • 15.5% of PEBB BRFS respondents are limited in activities due to physical, mental, or emotional problems • 46.2% of PEBB BRFS respondents have a chronic disease⁶ 	<ul style="list-style-type: none"> • 14.7% of OEBB BRFS respondents are limited in activities due to physical, mental or emotional problems • 47.4% of OEBB BRFS respondents have a chronic disease⁷ 	<ul style="list-style-type: none"> • 21.3% of BRFS respondents stated that they are limited in activities because of physical, mental, or emotional problems • 61.5% of BRFS respondents are at risk for chronic disease⁸
Socio-economic factors	<ul style="list-style-type: none"> • Household income – see eligibility notes above • Educational attainment is low (31.7% have some college and 55.6% completed grade 12 or less) • 48.6% of MBRFS respondents are food insecure • 22.3% of MBRFS respondents are more likely to be hungry 	<ul style="list-style-type: none"> • Household income: <ul style="list-style-type: none"> – 20.3% of PEBB BRFS respondents make \$25,000 to less than \$50,000 – 77.9% of PEBB BRFS respondents make \$50,000 or more • Educational attainment is high (71% graduated college and 	<ul style="list-style-type: none"> • Household income: <ul style="list-style-type: none"> – 24.1 % of OEBB BRFS respondents make \$25,000 to less than \$50,000 – 69.1% of OEBB BRFS respondents make \$50,000 or more • Educational attainment is high (71% graduated college 	<ul style="list-style-type: none"> • Household income: <ul style="list-style-type: none"> – 59.8% of all BRFS respondents (including those who might have coverage listed to left) make less than \$50,000 – 40.3% of all BRFS respondents make \$50,000 or more • Educational attainment is

⁵ Limited activity on 1+ days of last 30

⁶ Includes asthma, arthritis, diabetes, heart attack, heart diseases, stroke, cancer, or depression.

⁷ Ibid.

⁸ Based on BMI being greater than 25.0

Comparison of Oregon’s Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design				
	Oregon Health Plan	Public Employees’ Benefit Board (PEBB)	Oregon Educators’ Benefit Board (OEBB)	Commercial
		19% have some college)	and 17% have some college)	moderate (26.5% are college graduates and 35.4% attended some college) <ul style="list-style-type: none"> • 19.8% of all BRFSS respondents live in food insecure households
Out of pocket expenses	Generally there is no cost sharing, but adults receiving OHP Plus or OHP Limited Drug benefits have a \$3 copayment for certain types of outpatient services and a \$1 or \$3 copayment for certain prescription drugs (unless they are exempt)	<ul style="list-style-type: none"> • Kaiser OOP max– \$600/person, up to \$1200/family • All other plans OOP max – \$1500/person, up to \$4500/family 	<ul style="list-style-type: none"> • Kaiser OOP max – ranges from \$1500- \$5000/person, \$3000-\$10000/family • Moda OOP max – ranges from \$2400-\$5000, \$7200-\$12,700/family 	<ul style="list-style-type: none"> • OOP costs for Individual and small group plans on the exchange will vary depending on monthly premium and metal level • OOP max for non-grandfathered small and large group plans is \$6,600/person up to \$13,200/family (includes self-funded plans)
Benefit design	Robust medical, mental health and chemical dependency services and limited dental	Robust medical (includes vision), dental, and optional benefits (e.g., life insurance, short term disability insurance)	Robust medical (includes vision), dental, and optional benefits (e.g., life insurance, short term disability insurance)	<ul style="list-style-type: none"> • Individual and small group benefits are based on the Essential Health Benefits benchmark plan selected by the state <ul style="list-style-type: none"> – There are various limitations on scope, amount and duration of services – Dental and vision coverage must be purchased separately • Large group benefit offerings are likely more limited, especially in scope, amount and duration of services

Comparison of Oregon’s Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design

	Oregon Health Plan	Public Employees’ Benefit Board (PEBB)	Oregon Educators’ Benefit Board (OEGB)	Commercial
Participating carriers	<ul style="list-style-type: none"> • AllCare Health Plan • Cascade Health Alliance • Columbia Pacific CCO (plan partner-Care Oregon) • Eastern Oregon CCO (plan partner-Moda) • Family Care (plan partner-FamilyCare) • Health Share of Oregon (plan partners- CareOregon, Kaiser, Providence) • Intercommunity Health Network CCO (plan partner- Samaritan) • Jackson Care Connect (plan partner-CareOregon) • Pacific Source Community Solutions CCO Central Oregon (plan partner-PacificSource) • Pacific Source Community Solutions CCO Columbia Gorge (plan partner-PacificSource) • PrimaryHealth of Josephine County (plan partner- CareOregon) • Trillium Community Health Plan • Umpqua Health Alliance (plan partner- Atrio) • Western Oregon Advanced Health CCO • Willamette Valley Community Health (plan partner-Atrio) • Yamhill CCO (plan partner- 	<ul style="list-style-type: none"> • Kaiser Foundation Health Plan of Northwest covers 22,474 subscribers and dependents • AllCare Health Plan covers 1,575 subscribers and dependents • Moda Health Plan covers 2,947 subscribers and dependents • Providence Health Plan covers 105,883 subscribers and dependents • Trillium Community Health Plan covers 90 subscribers and dependents 	<ul style="list-style-type: none"> • Moda Health Plan covers 104,695 subscribers and dependents • Kaiser Permanente of the Northwest covers 24,700 subscribers and dependents 	<p>Individual (I), small group (SG), and large group (LG):</p> <ul style="list-style-type: none"> • Aetna (LG) • Atrio (I, SG) • Bridgespan Health Company (I) • Cigna (LG) • Connecticut General Life Insurance Company (LG) • Health Net Health Plan of Oregon (I, SG, LG off exchange) • Health Republic Insurance (Freelancers CO-OP) (I, SG) • Kaiser (I, SG, LG) • Lifewise Health Plan of Oregon (I, SG, LG) • Moda (I, SG, LG) • Oregon’s health CO-OP (I, SG, LG on exchange only) • Pacific Source (I, SG, LG) • Providence (I, SG, LG) • Regence Blue Cross Blue Shield (I, SG, LG off exchange only) • Samaritan (SG off exchange only) • Time Insurance Company (I off exchange) • Trillium (I, SG) • United Healthcare Insurance Company (SG, LG off exchange) • UnitedHealthcare of Oregon (SG, LG off exchange)

Comparison of Oregon's Commercial and Public Health Insurance Market Segments: Covered Populations and Plan Design				
	Oregon Health Plan	Public Employees' Benefit Board (PEBB)	Oregon Educators' Benefit Board (OEBB)	Commercial
	CareOregon) Enrollment information is available at http://www.oregon.gov/oha/healthplan/pages/reports.aspx			
Regulatory entities	<ul style="list-style-type: none"> • Social Security Act Title 19 and Title 21 • July 2012 1115 Waiver Demonstration 	<ul style="list-style-type: none"> • Oregon legislature (ORS 243.061 to 243.145) • PEBB Board • Collective bargaining 	<ul style="list-style-type: none"> • Oregon legislature (ORS 243.860 to 243.886) • OEBB Board • Collective bargaining 	<ul style="list-style-type: none"> • Collective bargaining • Essential Health Benefits for individual and small group 45 CFR Parts 147, 155, and 156 • Oregon Insurance Division (does not regulate self-insured market segment)

Sources:

- 2014 Medicaid BRFSS Survey (<http://www.oregon.gov/oha/analytics/MBRFSS%20Docs/2014%20MBRFSS%20State%20Total%20Data%20Tables.pdf>)
- Oregon Health Plan data and reports – June 25, 2015 (<http://www.oregon.gov/oha/healthplan/DataReportsDocs/June%202015%20Coordinated%20Care%20Service%20Delivery%20by%20County.pdf>)
- 2013 BRFSS of State Employees (report is unpublished)
- PEBB website and member handbook <http://www.oregon.gov/DAS/PEBB/pages/index.aspx>
- 2013 BRFSS of School Employees (<https://apps.state.or.us/Forms/Served/oe9956.pdf>)
- OEBB website and member handbook <http://www.oregon.gov/oha/OEBB/Pages/Member-Benefits.aspx>
- 2011 and 2013 Oregon Behavioral Risk Factor Surveillance System (BRFSS) (<https://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/brfssresults/Pages/index.aspx>)
- OHSU Impacts of the Affordable Care Act on Health Insurance Coverage in Oregon: County Results/Statewide Update <http://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/upload/Health-Insurance-Coverage-in-Oregon-County-Results.pdf>
- Oregon Insurance Division website <http://www.oregon.gov/DCBS/insurance/insurers/other/Pages/quarterly-enrollment-charts.aspx>

Appendix B

Coordinated Care Model – Carrier Interview Questions

Overview

The vision of Governor Kitzhaber and the Oregon Health Policy Board is that broader adoption of Coordinated Care Model (CCM) principles will unite Oregon’s markets in the drive towards achieving the triple aim of better health, better health care, and lower costs. To begin to understand the current health insurance market landscape, the Office of Health Policy and Research (OHPR) will conduct interviews with carriers to understand commitment to the principles of the CCM and programmatic and operational efforts to adopt it, including challenges, needs, and the resources available to facilitate the spread of the CCM.

Through these questions, the State will aim to obtain information from carriers in the following areas:

- Carrier programs/operations supporting the CCM;
- Provider (hospital and physician) interest and readiness;
- Challenges/barriers for further spread;
- Needs of the market segment constraining the ability to spread the model; and
- Resources available to facilitate the adoption of the model.

General Plan Information

We would like to understand the market segments served by your plan and how many lives you serve in each segment.

Market	Covered Lives	Sample Employers
Individual		
Small Group (fully insured)		
Large Group (fully insured)		
Self-Insured		
Medicaid		
Medicare Advantage		

Coordinated Care Model (CCM)

As you know, Oregon has developed a Coordinated Care Model and implemented it for the Medicaid program via contracts with Coordinated Care Organizations. [Review CCM Model with interviewee]

1. Are you familiar with the Coordinated Care Model? If yes, what aspects of the model are of interest to you? Are there aspects of the model you are not inclined to implement within your offerings?
2. [If no, provide an explanation.] Do you believe, based on what I have described, your organization is utilizing similar principles in the coverage you are providing. If not, where are the points of divergence?
3. If you offer a Medicare Advantage plan are there any specific barriers to implementing the CCM based on Medicare rules?

Strategies to Change Patient Behavior

We are interested in activities you have undertaken that may influence a consumer's behavior in terms of choosing providers and engaging in care.

1. Please describe your efforts to implement patient (member) behavior change strategies, including any notable employee or provider reaction to such efforts:
 - a. Transparency of provider performance on:
 - i. Quality
 - ii. Cost or efficiency, including relative to a member's deductible and coinsurance
 - b. Tiered networks
 - i. Please describe the patterns of service delivery in your market and whether there are any providers that are seen as "must haves" in any provider network.
 - ii. How do you tier the network? Is it based on quality, cost or a combination?
 - c. High Performing (select) networks
 - d. Value-based benefit design
 - i. Incentives for use of preventive services
 - ii. Incentives for healthy behaviors
 - iii. Incentives for use of evidence-based services
 - e. Wellness programs and/or tools
 - f. Shared decision making tools
 - g. Patient activation or engagement in management of health conditions
2. How do your products address social determinants of health, if at all? Do you offer any assistance in addressing social needs that impact health?

Payment and Delivery Innovations

We are interested in understanding the activities you have undertaken to move from fee-for-service payment; support providers in transformation to new payment and delivery models, and the financial and non-financial incentives that you have used to bolster provider accountability.

3. Has your organization participated in any reforms to the fee-for-service payment system as described below?
 - a. Implementation of non-payment and/or reporting of adverse events?
 - b. Use of supplemental payments for PCPCH (Medical Home) and/or clinical care management programs?
 - c. Institution of reference pricing for treatments and/or procedures?
4. Has your organization encouraged (through contractual requirements or through financial or non-financial incentives) and supported (with reports, payment, TA or other resources) the following activities among providers?
 - a. Care coordination and continuity of care for members, especially for individuals with complex needs
 - b. Patient-centered models of care
 - c. Integration of physical health, mental health, and addictions services

- d. Programs for high-risk members (e.g., case management, disease management, pharmacy benefit management)
5. Please describe your organization's efforts in the area of Health Information Technology that have resulted in increased access and sharing among providers and care delivery improvements.
 - a. Adoption and meaningful use of EHRs and health information exchange
 - b. Telehealth programs
 - c. Provision of data, reports and/or analytics tools to contracted providers
 - d. Other efforts
 6. Please describe any intent or actions to adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup. If no actions have been taken, are you open to using a common measure set in your performance-based contracts with providers?
 7. Please describe your organization's past and current attempts at payment innovation and provider accountability (P4P, PCPCH supplemental payment, shared savings and/or risk, capitation, bundled payment), including the scale and impact of the efforts. What percentages of your covered lives or payments roughly fall under one or more of these models at present?
 8. What, if anything, have you done in your contracts with providers to slow the effects of provider price growth on medical trend?

Appendix C

Coordinated Care Model – Large Employer Interview Questions

Overview

The vision of Governor Kitzhaber and the Oregon Health Policy Board is that broader adoption of Coordinated Care Model (CCM) principles will unite Oregon’s markets in the drive towards achieving the triple aim of better health, better health care, and lower costs. To begin to understand the current health insurance market landscape, the Office of Health Policy and Research (OHPR) will conduct interviews with employers to understand their interest in incorporating the principles of the CCM into their health benefits purchasing practices, including the steps they have or will take. The interviews will also query employers about the challenges, needs, and the resources available to facilitate the spread of the CCM.

Through these questions, the State will aim to obtain information from employers in the following areas:

- Employer support for the CCM;
- Employer challenges/barriers to CCM spread;
- Perceived carrier interest and readiness;
- Resources available to employers to facilitate the adoption of the model.

General Purchasing Information

We would like to understand how many lives are covered through your purchasing and from which carriers you purchase health coverage.

1. Is your organization self-insured or fully insured?
2. Do you provide health coverage as part of a defined benefit package or a defined contribution (e.g., do employees have a set amount of funding to put towards health coverage and other benefits)?
3. How many plans do you offer to your employees, and from which carriers?
4. If you offer more than one plan design, what is the plan design the largest group of employees select?
[insert table with basic descriptive variables]
5. How many individuals do you purchase coverage for by carrier and plan type?
6. Do you receive outside assistance in devising your health benefits and wellness strategies? If so, who provides that support?
 - a. Broker
 - b. Health benefits consultant
 - c. Wellness consultant or vendor
 - d. Plan administrator/carrier
 - e. Employer coalition

Coordinated Care Model (CCM)

As you may know, Oregon has developed a Coordinated Care Model and implemented it for the Medicaid program via contracts with Coordinated Care Organizations. [Review CCM Model with interviewee]

4. Are you familiar with the Coordinated Care Model? If yes, what aspects of the model are of interest to you? Are there aspects of the model that you would not be inclined to request carriers to implement?
5. [If no, provide an explanation.] Do you believe, based on what I have described, your organization is utilizing similar principles to the CCM. If not completely, where are the points of divergence?

Strategies to Change Patient Behavior

We are interested in activities you have undertaken that may influence a consumer's behavior in terms of choosing providers and engaging in care.

9. Does your health benefits strategy include efforts to motivate patient (member) behavior change strategies, such as:
 - a. Transparency of provider performance on:
 - i. Quality
 - ii. Cost or efficiency, including relative to a member's deductible and coinsurance
 - b. Tiered networks
 - i. If you include tiered networks, are they tiered based on quality, cost or a combination?
 - c. High Performing (select) networks
 - i. Are there any "must have" providers that you feel you must have available to your employees?
 - d. Value-based benefit design
 - i. Incentives for use of preventive services
 - ii. Incentives for healthy behaviors
 - iii. Incentives for use of evidence-based services
 - e. Wellness programs and/or tools
 - i. HRA
 - ii. health coaching
 - iii. weight loss
 - iv. smoking cessation
 - v. exercise
 - vi. stress reduction
 - f. Shared clinical decision making tools
10. Does your health benefit strategy address social determinants of health? Do you offer any assistance in addressing social needs that impact health?

Payment and Delivery Innovations

We are interested in understanding whether you have directed your carrier(s) to take steps with its contracted providers to a) move away from fee-for-service payment; b) support providers in transformation to new payment and delivery models, and c) use the financial and non-financial incentives to bolster provider accountability.

1. Does your organization participate in an Employer Coalition focused on health purchasing?
2. Has your organization participated included any of the following within its carrier agreements?
 - a. Implementation of non-payment and/or reporting of adverse events?
 - b. Institution of reference pricing for treatments and/or procedures?
3. Do your agreements with carriers require any of the following activities?
 - a. Patient-centered models of care (e.g., PCPCH)
 - b. Integration of physical health, mental health, and addictions service delivery

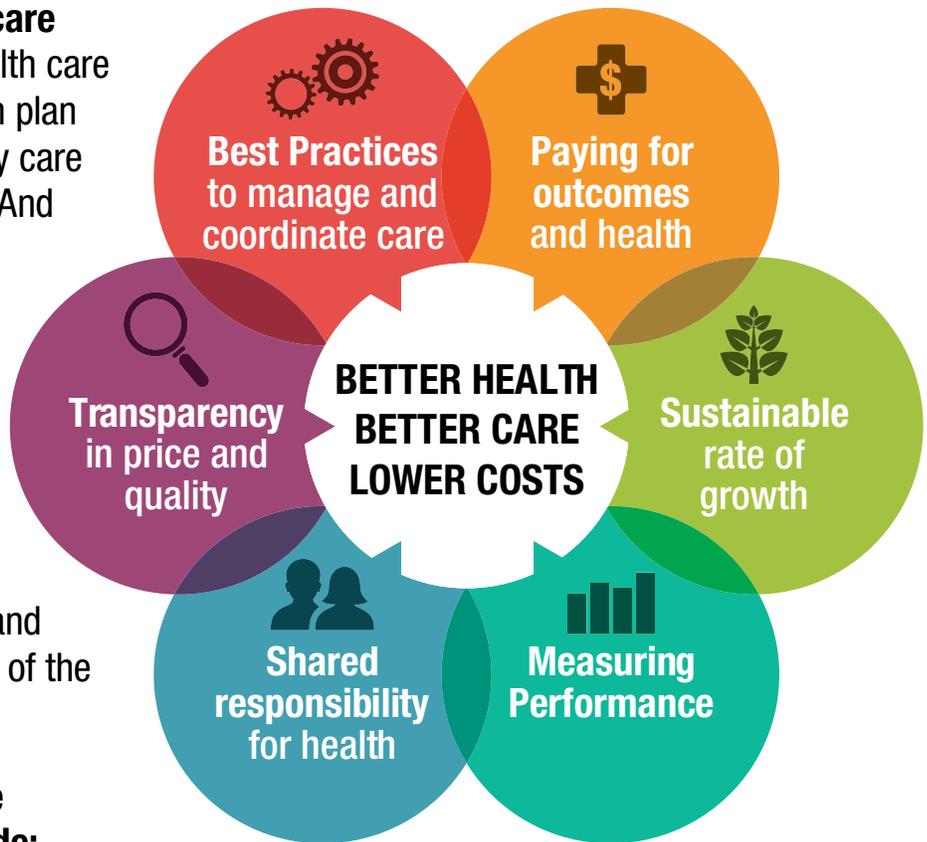
- c. Programs for high-risk members (e.g., case management, disease management, pharmacy benefit management)
 - d. Care coordination for members, especially for individuals with complex needs
- 4. Do your agreements with carriers include any requirements regarding Health Information Technology that may increase access and sharing among providers and care delivery improvements?
 - a. Adoption and meaningful use of EHRs and participation in a health information exchange
 - b. Telehealth programs
 - c. Provision of data, reports and/or analytics tools to contracted providers
 - d. Other efforts (please specify)
- 5. Please describe how your organization looks at the quality of care provided to your employees and their dependents at both the health plan level and at the provider level. Are there any incentives in your agreements based on the quality of care?
- 6. Are you familiar with the provider performance measures developed by the Health Plan Quality Measures Workgroup? Do you plan to require your carriers to implement them?
- 7. Do your agreements with carriers include any requirements regarding payment innovation and provider accountability, such as:
 - a. P4P
 - b. PCPCH supplemental payment
 - c. care management supplemental payment (if distinct from PCPCH)
 - d. shared savings and/or risk
 - e. capitation
 - f. bundled payment

Do you have any sense of what percentage of your covered lives or payments roughly fall under one or more of these models at present?

Oregon's coordinated care model

Better health, better care, lower costs: The Oregon Way

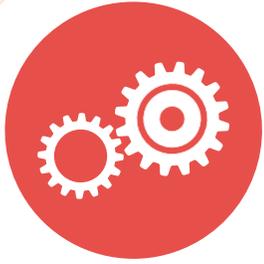
Through the coordinated care model, those paying for health care get a better value and health plan consumers get higher quality care at a price we can all afford. And Oregonians are experiencing improved, more integrated care. With a focus on primary care and prevention, health plans and their providers using the coordinated care model are able to better manage chronic conditions and keep people healthy and out of the emergency department.



Oregon's coordinated care model key elements include:

-  **Best practices to manage and coordinate care**
-  **Shared responsibility for health**
-  **Transparency in price and quality**
-  **Measuring performance**
-  **Paying for outcomes and health**
-  **A sustainable rate of growth**

Separately, these elements all assist in producing better health outcomes at lower prices. When all elements are used together, they are the most effective in achieving better health, better care and lower costs.



Using best practices to manage and coordinate care

The model is built on the use of evidence-based best practices to manage and coordinate care. This produces better care, improved outcomes (including a positive patient experience) and lower costs.

Best practices include:

- Value-based benefit design that create incentives for consumers to use evidence-based services.
- These services are the most effective for cost and quality, so they cost less for consumers, their employers or purchasers, and health plans.
- Identification of a primary care clinician as the individual's regular source of care.
- Patient-centered primary care homes that provide team-based care. Care coordination through primary care homes is essential for patients with chronic health conditions.
- Behavioral, physical and dental health care integrated through evidence-based best practices. Evidence-based practices such as shared treatment plans and co-location of services are designed to maximize outcomes and efficiency, and eliminate waste.
- Providers and health systems use electronic health records and information exchange across care settings. These systems improve data accuracy, allowing for better patient care, while reducing costs associated with duplicate or unnecessary services.
- Culturally and linguistically appropriate care.

What it means for

The purchaser of health benefits

- ✓ Lower costs as the result of better quality care and better health outcomes
- ✓ A central point of contact for navigation of services

Your employees

- ✓ Higher quality care and better health outcomes
- ✓ Streamlined information sharing, due to electronic health records and care coordination
- ✓ Improved patient experience
- ✓ Prevention-focused health strategies
- ✓ Improved care coordination, especially for those with chronic health conditions

The health plan

- ✓ Providers are using evidence-based best practices
- ✓ More robust picture of members
- ✓ Information from more care delivery points is available (dental, physical, mental)
- ✓ Case management efficiencies developed



Shared responsibility for health

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and consumers can share responsibility and decision-making for care, while coming to joint agreements on how the individual wants to improve or maintain positive health behaviors.

Shared responsibility for health results from:

- Shared decision-making. Providers use shared decision-making as a standard of care with patients and their family members, as appropriate, as well as strategies that activate patients to take charge of their health and any chronic condition needing management.
- Health plan members taking a health risk assessment. This is one of the first key steps in becoming involved in one's own health outcomes.
- Benefits that provide incentives for preventive care and healthy behavior, and support the use of evidence based services. This can include low- and no-cost services for evidence-based screenings, well-child visits and other preventive services. Incentives can be used for personal health behaviors and improved health status using evidence-based strategies relating to diet, exercise, smoking and medication use. Services that are not evidence-based would be more expensive, while evidence-based services would cost less.
- Consumer and community engagement and collaboration. Involving consumers and community members in advising health plans and practices through consumer advisory councils, and regular opportunities for feedback from consumers improves opportunities for shared responsibility for health. Additionally, collaboration with other entities such as public health, non-profits, and local government improves opportunities for shared responsibility for the health of the community.

What it means for

The purchaser of health benefits

- ✓ Cost savings achieved through healthier members and use of higher quality, evidence-based services and preventive services.
- ✓ Healthier employees who are more engaged in their health.

Your employees

- ✓ Better health through incentives, awareness and ownership of one's own health.
- ✓ Individual savings and improved health by using preventive care and evidence-based services.

The health plan

- ✓ Healthier, more involved health members.
- ✓ Better knowledge of members' health through assessments; allow the plan to focus on interventions when and where needed.
- ✓ Cost savings achieved through healthier members and providers' use of higher quality, evidence-based services.



Transparency in price and quality

Cost and quality data that is readily available, reliable and clear helps patients understand their health plan and provider choices and it helps purchasers make decisions about choosing health plans. With access to data, patients can share responsibility in their health care decisions. Increased transparency on price and quality can also lead to increased accountability.

Transparency in price and quality means:

- Transparency of prices to allow for comparisons of providers.
- Clear information about the price of specific services. This includes information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans.
- Transparency of provider performance on quality. Information on quality, patient experience, and volume is readily and clearly available to plan participants when the nationally recognized or endorsed measures of hospital and physician performance are used.

What it means for

The purchaser of health benefits

- ✓ Allows you and your employees to make decisions based on price and quality.
- ✓ Provides improved understanding of the costs of health care decisions.

Your employees

- ✓ Better health through incentives, awareness and ownership of one's own health.
- ✓ Individual savings and improved health by using preventive care and evidence-based services.

The health plan

- ✓ Allows for a more transparent view of provider performance. This information allows health plans to provide incentives for quality over quantity.
- ✓ Strategic insight into contracting.



Measure performance

Performance measurement that's consistent across health systems improves opportunities, performance, and accountability, while easing providers' reporting burden. It may also help improve the quality of care in the health system as a whole.

Successful performance measurement comes through:

- An aligned, consistent measure set. Measures are consistent across major public and private payers, including commonly defined measures in each of the following areas: access, quality, patient satisfaction, patient activation, service utilization, and cost.
- Regular analysis of information.
- Provider-level and administrator-level measurement. Performance is measured at the clinician, practice team or practice site, and organizational levels. Also, measure performance across all provider types and providers with meaningful volume for the health plan.

What it means for

The purchaser of health benefits

- ✓ Allows you and your employees to make decisions based on price and quality.

Your employees

- ✓ Informed decision-making when choosing provider and health plan.

The health plan

- ✓ Allows for a more transparent view of provider performance and with this information, allows health plans to provide incentives for quality over quantity.



Pay for outcomes and health

Paying for better quality care and better health outcomes, rather than just more services, is essential to the model. Innovative payment methods such as population and episode-based payments, and offering incentives for quality outcomes instead of volume-based fees support better care and lower costs.

Innovative ways of paying include:

- Pay providers according to performance. Providers who perform better can be paid more.
- Design payment and coverage approaches that cut waste while not diminishing quality. This includes reducing unjustified variation in payments, not paying for avoidable complications and hospital-acquired infections, or lower payments for unnecessary services.
- Support primary care. A robust primary care system is at the heart of the model; primary care payments should support both an effective primary care infrastructure and the provision of high-quality primary and preventive services.
- Increasing the proportion of total payments based on performance over time, or implementing a population-based model where the plan and providers share financial risk.

What it means for

The purchaser of health benefits

- ✓ Healthier employees. All members receive high-quality preventive health care and for those with chronic health conditions, care will be better managed.

Your employees

- ✓ High-quality preventive care.
- ✓ Team-based care helps those with chronic health conditions better manage their condition and keeps them in their best health.

The health plan

- ✓ Cost savings achieved through healthier members, use of higher quality, evidence-based services by providers, and cutting waste.
- ✓ Ability to support different payment structures for higher performing providers.



Sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model – and one that strengthens all other principles. Preventing a cost shift to employers, individuals, and families, and reducing inappropriate use and costs through a fixed-rate-of-growth approach is the foundation to health care transformation.

Achieving a sustainable rate of growth results from:

- Population-based contracts that include risk-adjusted annual increases in the total cost of care for services reimbursed.
- Provider contracts that include provisions that agree on rates and quality incentive payments for each contract year.

What it means for

The purchaser of health benefits

- ✓ A better understanding of health plan costs, how they'll grow over time, and the ability to budget over long periods of time.

Your employees

- ✓ Costs savings, and more affordable premiums, co-pays and co-insurance.

The health plan

- ✓ A better understanding of costs and how they'll grow over time.

Coordinated Care Model Alignment Work Group

Operationalizing the Principles of Oregon's Coordinated Care Model: A High-Level Framework for Procurement and Contracting

This framework is designed to be used by self-insured purchasers, however similar language can be used for a fully-insured product. It is by design written at a relatively high level. The framework includes the critical elements of the model. For procurement purposes, additional detail would be required in most instances. Some concepts, such as value-based benefit design, fall under a number of the elements. For the purposes of this framework they are included in one place. These Coordinated Care Model elements may be phased in over time if an employer is not able to implement all pieces at once. As evidenced throughout this document, a number of the Coordinated Care Model elements include specific measures or targets that could be adopted to encourage progress towards transformation of specific areas, included in this document. These targets should serve as a guide to measure progress and are an option for those interested in being more transformative, but each purchaser may develop targets that are appropriate given their current baseline.

Other content, such as reporting requirements and value-based purchasing language, while important, fall outside the scope of this framework and are not included.

I. Use best practices to manage and coordinate care

Application of evidence-based best practices of care delivery produces better care, improved outcomes and lower costs, and creates a positive patient experience.

- 1. Primary care clinician.** Plan Participant shall be required to identify a primary care clinician. The Administrator shall make sure each Plan Participant has an identified primary care clinician and the clinician establishes a relationship with every attributed Plan Participant if one does not already exist at the time of enrollment.
- 2. PCPCH.** The Administrator shall encourage its contracted primary care practices to operate as a high-functioning Patient Centered Primary Care Home (PCPCH) or Patient Centered Medical Home (as defined by NCQA) or similar primary care transformation, hold PCPCHs accountable for performance, and support PCPCH/PCMHs with needed payer-supplied data, not limited to high-risk patient lists, costs of referral providers, information regarding non-primary care utilization, and quality information, utilization and cost measures for attributed Plan Participants. More information about Oregon's Patient Centered Primary Care Home Program is available at www.oregon.gov/oha/pcpch/Pages/index.aspx.

- **Examples of Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
 - The Administrator shall require that 85% of enrollees receive services from contracted primary care practices that operate as high-functioning PCPCHs (aggressive)
 - The Administrator shall require that 75% of enrollees receive services from contracted primary care practices that operate as high-functioning PCPCHs (moderate)
 - The Administrator shall require that 65% of enrollees receive services from contracted primary care practices to operate as high-functioning PCPCHs (easier)
- 3. Team-based care.** The Administrator’s contracted providers shall be encouraged to provide patient-centered, team-based care across appropriate disciplines through the application of a common, shared care plan and clinical information exchange. The Administrator shall ensure providers are knowledgeable in the clinical evidence for patient-centered team-based care and are increasingly practicing in such manner over the term of the contract.
- **Examples of Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
 - The Administrator’s contracted providers shall be required to provide patient-centered, team-based care. (very aggressive)
 - The Administrator’s contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract. (very aggressive)
 - 75% of the Administrator’s contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (aggressive)
 - 50% of the Administrator’s contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (moderate)
 - 25% of the Administrator’s contracted providers shall be required to provide patient-centered, team-based care by Year 3 of the contract (easier).
- 4. Care coordination.** The Administrator shall ensure the provision of care coordination for patients at high-risk of future intensive service use. Care coordination may be provided through a combination of PCPCHs, coordinated care

entities (such as CCOs or ACOs), and the Administrator. Where care coordination is available to a consumer through more than one organization, the Administrator shall ensure these efforts are coordinated. Care coordination shall include integration of long-term services and supports (LTSS) with needed health care services, and shall leverage community-based human services to address social determinants of health, including housing and employment and coordination of population health. (LTSS: Medicaid only).

5. **Behavioral/physical health integration.** Behavioral health and primary care services shall be integrated through the application of evidence-based best practice strategies, including but not limited to co-location (including reverse co-location, which is defined as placement of primary care resources in community mental health settings), use of an integrated medical record, use of a shared treatment plan, and integrated payment.
6. **Clinical protocols.** Contracted providers shall be required to specify and implement clinical protocols reflective of evidence-based practice, designed to maximize patient health status, clinical outcomes and efficiency, and to eliminate overuse (waste). For example, a clinical protocol may include a treatment plan for treating an individual with COPD or stroke management.
7. **Formulary development.** The Administrator shall develop a formulary design that includes prescription drug coverage for each therapeutic class, but is flexible enough for patient-centered approaches, including access to products outside the formulary under special circumstances. The formulary should be reviewed and amended at a minimum on an annual basis.
8. **Electronic Health Record (EHR).** Contracted physician providers shall be required to adopt and fully utilize certified Electronic Health Records (EHR) systems across care settings. Such providers shall implement systems to ensure data completeness and accuracy.
 - **Examples of Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
 - All contracted providers, beyond the contracted physician providers noted above, shall be required to adopt and fully utilize certified, interoperable EHRs. (very aggressive)
 - Purchasers and providers shall ensure that patients have secure access to their clinical health records electronically, such as through a patient portal, as well as ensure patients have the capacity to share information electronically with their providers.

- 9. Health information exchange.** Contracted physician and hospital providers shall be encouraged to use real-time electronic clinical information exchange across all care settings.
- **Examples of Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
 - Contracted physician and hospital providers shall be required to use real-time electronic clinical information exchange across care settings. (aggressive)
 - All contracted providers, beyond the contracted physician and hospital providers, shall be required to use real-time electronic clinical information exchange across all care settings (very aggressive)
- 10. Value-Based Network Design.** Value-Based Network Design is the explicit use of employee plan benefits to create consumer incentives for use of high performance providers who adhere to evidence-based treatment guidelines.
- a. **Tiered network.** The Administrator shall make available to the Purchaser a benefit design that varies cost-sharing by provider performance. For example, the highest performing providers and/or centers of excellence are placed in Tier 1 with the lowest cost-sharing, while the lowest performing providers on a set of quality metrics are placed in Tier 3 with the highest cost sharing.
 - b. **High-performing network.** The Administrator shall make available to the Purchaser a high-performing network limited to providers who have distinguished themselves based on evidence-based, statistically meaningful and risk-adjusted measures of quality as well as risk-adjusted measurement of cost and efficiency.
- 11. Use of telemedicine.** The Administrator shall support provision of covered telemedicine services.

II. Share responsibility for health

When providers, payers and consumers work together, improving health becomes a team effort. Informed, engaged, and empowered providers and patients/consumers can share responsibility and decision-making for care, while coming to joint agreement on accountability for individual health behaviors.

1. **Shared decision-making.** Contracted providers shall be expected to make shared decision-making a standard of care with patients and their family members (as appropriate), utilizing tools such as personal health self-assessments and technologies such as video and web-based decision aids to support the process.

2. **Benefit design incentives for preventive care.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for evidence-based screenings, well-child visits and other preventive care services. For example, incentives could include enriched benefit coverage, reduced cost-sharing and “extras” such as car seats and gym memberships
3. **Benefit design incentives for health behaviors.** The Administrator shall make available to the Purchaser and its Plan Participants benefit design incentives for personal health behaviors and improved health status using evidence-based strategies relating to diet, exercise, tobacco use and medication adherence. For example, incentives could include enriched benefit coverage, reduced cost sharing and “extras” such as gym memberships.
4. **Benefit design for evidence-based services.** The Administrator shall propose for Purchaser consideration a benefit design that varies cost-sharing for services which are nationally recognized as over-used or being driven by supply and/or physician preference rather than evidence-based practice. For example, this may include incentivizing the use of physical therapy without cost-sharing for back pain prior to receiving an MRI or reducing cost-sharing for prescription drugs related to chronic conditions such as diabetes.
5. **Patient activation.** Contracted providers shall be expected to utilize strategies that activate patients to take charge of their health and any chronic condition needing management. Such strategies shall include provider training, use of standardized assessment instruments and differentiated patient activation strategies based on assessment results.
6. **Health Risk Assessment.** The Administrators shall provide for a Health Risk Assessment and request its completion by each adult Plan Participant.

III. Measure performance

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.

1. **Aligned measure set.** The Administrator shall adopt and utilize the set of provider performance measures developed by the Health Plan Quality Measures Workgroup (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.

2. **Administrator health informatics.** The Administrator 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.
 - **Examples of Specific Measure That Could Be Adopted to Meet The Above Requirements:**
 - **Provider health informatics.** The Administrator shall require contracted providers operating under population-based contracts to 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
3. **Administrator-level measurement.** The Administrator shall measure performance across all provider types and providers with meaningful volume for the Administrator’s book of business.
4. **Provider-level measurement.** The Administrator shall require contracted providers to measure performance at the clinician, practice team and/or practice site, and organizational levels.
5. **Population measurement adjustment.** The Administrator shall apply clinical risk adjustment techniques when measuring provider performance and utilize socio-economic risk-adjustment techniques to the extent available.

IV. Pay for outcomes and health

Payment for care should be based on quality and health outcomes rather than on volume of services provided. Alternative payment methodologies (APMs) such as population-based payment, episode-based payment, and offering incentives for performance and quality outcomes all support better care and decreased cost growth. The intent, over time, is to increase the use of systems of payment that improve health outcomes.

1. **Population-based contracting (global payment).** The Administrator shall take such actions as are necessary to annually increase the proportion of providers agreeing to meet the following population-based contracting requirements:
 - **Examples of Specific Measures That Could Be Adopted to Meet The Above Requirements** (note: these options allow carriers to gradually increase to the levels included below as is appropriate given their current baseline):
 - By the end of Contract Year 3, claims for at least 60 percent of insured 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)

- By the end of Contract Year 3, claims for at least 45 percent of insured 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)
- By the end of Contract Year 3, claims for at least 30 percent of insured lives shall be covered under a population-based contract with shared savings or with risk sharing. (easier)

2. **Pay providers, including both those operating under population-based contracts and those not, differentially according to performance.** The Administrator shall evaluate and implement successful programs to differentiate providers who meet or exceed state or national standards for quality and efficiency. Compensation paid to effective and efficient providers should reflect their performance and result in market efficiencies and savings to purchasers and payers. Examples include quality-based incentive payments, differential fee schedules, and fee increases at risk based on provider performance.
3. **Develop episode-based payment strategies.** The Administrator shall work with its provider network shall evaluate and implement episode-based payment strategies designed to bundle a set of services together that are related to a defined treatment (e.g., knee replacement surgery).
4. **Design payment and coverage approaches that cut waste while not diminishing quality, including reducing unwarranted payment variation.** The Administrator shall evaluate and implement successful approaches to payment designed to cut waste while not diminishing quality. Examples include, but are not limited to, reference pricing, non-payment for avoidable complications and hospital-acquired infections, lower payment for non-indicated services and warranties on discharges for patients who undergo procedures.
5. **Support primary care.** The Administrator shall support Patient Centered Primary Care Home (PCPCHs) or similar primary care transformation, 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.

V. Provide information so patients and providers know price and quality

Readily available, accurate, reliable and understandable cost and quality data can help patients understand health care plan choices, and share responsibility in treatment, care management, and other health care decisions. Increased transparency on price and quality can also lead to increased accountability for providers.

- 1. Fully disclose quality performance to facilitate comparisons of providers.** The Administrator shall develop and implement a strategy to report the comparative performance of Providers, using the most current nationally-recognized or endorsed measures of hospital and physician performance. Information delivered through the Administrator's provider ranking programs should be meaningful to Plan Participants and reflect a diverse array of provider clinical attributes and activities. Information available to Plan Participants should include, but not be limited to, provider background, quality performance including specific to high-volume interventional services, patient experience, volume, and should be integrated into and accessible through one forum providing Plan Participants with a comprehensive view.
- 2. Fully disclose prices to facilitate price comparisons of providers.** The Administrator shall, where permitted, make specific price information (including the price being paid to specific providers) transparent and available for use by Company and its Plan Participants, including those in consumer-directed plans. This price transparency shall cover services representing at least 80% of the Administrator's medical spend in all markets, The disclosed information shall be based on the contracted price of specific procedures and services including, without limitation, reasonable and customary estimates, to facilitate Plan Participants' informed choice of treatment and care decisions.
- 3. Combine projected price information with Plan Participants' benefit design.** The Administrator shall identify and engage third-party vendors, if any are necessary, to enable the Administrator to integrate tools providing information about the price of specific services with information about the benefit design, such as deductibles, coinsurance, and balance of account-based plans. The Administrator shall align with future transparency efforts led by the Oregon Insurance Division or other state entities.

VI. Establish a sustainable rate of growth

Bending the cost curve is a vital component of the coordinated care model that fortifies all other principles. Preventing a cost shift to employers, individuals, and families and reducing inappropriate utilization and costs through a fixed rate of growth approach is foundational to health care transformation in Oregon.

- 1. Population cost growth.** Population-based contracts shall include a provision that the risk-adjusted annual increase in the total cost of care for services reimbursed under the contract shall be informed by the efforts of the Oregon Health Authority, such as the Sustainable Health Expenditure Work Group or a similar Oregon Health Policy Board work group.
- 2. Provider price growth.** Provider contracts, including but not limited to hospital and physician contracts, shall include a provision that agrees on rates, and quality incentive payments for each contract year, informed by the work of the Oregon Health Authority, such as the Sustainable Health Expenditure Work Group or a similar Oregon Health Policy work group.

Defined Terms

Administrator – the entity responsible for providing third party Plan administration services on behalf of an employer purchaser and contracting with a provider organization(s) representing a defined network for purposes of providing benefits to Plan Participants.

Behavioral Health – services related to both mental health and addiction

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

Employer – sponsor of a group health plan with specified benefit coverage through the Administrator.

Patient Centered Primary Care Home (PCPCH) – a primary care practice which meets the State criteria for a PCPCH as defined at <http://www.oregon.gov/oha/pcpch/Pages/standards.aspx>.

Plan – the set of benefits offered by the Employer through the Administrator through an agreement.

Plan Participant – employees, dependents and retirees of the Employer who are eligible to receive their health benefits under the Plan.

Population-based Payment – a comprehensive payment to a group of providers to account for all or most of the care that will be received by a group of patients for a defined period of time.

Primary Care Clinician – a Provider focuses his or her practice on the provision of primary care; a Primary Care Clinician may include pediatricians, family physicians, nurse practitioners, internists, and based on a Plan Participant's diagnoses, may also include a specialty physician upon agreement by that physician and approval by the Administrator.

Provider - primary care and specialty physicians, hospitals, outpatient and ancillary facilities participating in the Administrator's network for the purposes of this Plan.

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 Model Contract could also be used by fully-insured employers in agreements with health insurers. In addition, the Model Contract can be used by employers regardless of whether all of their employees are located in Oregon.² The concepts of the CCM are not unique to Oregon and are being implemented nationally by employers.

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 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 also details requirements related to managing the provider network.

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

² One exception may be the specific quality measurement language, which may need to be modified to incorporate measurement alignment across states and not just in Oregon.

- Evidence-Based Care: This section is focused on requirements to provide evidence-based care, and the monitoring of adherence to those requirements.
- 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.
- Information Technology: This section focuses on the IT 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 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. In addition, the Employer's agreement with the TPA will include a separate document that provides a detailed description of Covered Services and cost-sharing parameters.

Where the Model Contract includes explanatory language for the purchaser that would not be part of an agreement with a TPA, 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 finding, assessing and

implementing 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, which 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.

Primary Care Provider (PCP) 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.

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

Provider means 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 means 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.

Telemedicine means the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine 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 administrative services to support 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 required by the Employer under the Contract. At a minimum, services shall meet the Essential Health Benefits requirements of the Affordable Care Act.
 - i. The TPA shall implement cost-sharing and benefit design options elected by the Employer that incentivize Participants to access preventive care and evidence-based services and engage in healthy behaviors.

b. Primary Care Provider (PCP):

- i. All Participants shall be required to identify a PCP to provide primary care services.
- ii. TPA shall develop a process through which Participants select a PCP.
 1. The TPA's provider directory shall include all available PCPs within the TPA's network. As detailed in Section III below, the provider directory shall include information to assist a Participant in selecting the most appropriate PCP for his or her needs.
 2. The TPA shall provide the Participant with information on how to select a PCP upon enrollment, including but not limited to:
 - a. How long a Participant has to select a PCP
 - b. How the Participant selects the PCP
 - c. How a PCP will be assigned to plan participants who do not select a PCP.
 - d. Whether and how often a Participant shall have the option to select a different PCP.
 3. The TPA shall require PCPs to reach out to plan participants who have selected or been assigned to them specifically to establish a relationship with each attributed Participant if the clinician has never treated the Participant. The requirement shall describe how the PCP 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 Primary Care Providers. 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 patients who do not meet requirement for care management services, but 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 TPA 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 Primary Care Providers 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 or preferred drug list 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 Telemedicine:** Where appropriate, TPA shall authorize health care services to be provided through telemedicine to increase access and treatment and 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 Provider Network shall include sufficient capacity so that Participants may access services within a 30- minute travel time for primary care and acute care services, and within an hour for specialty care.
 - iii. The TPA will ensure sufficient 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.
 - iv. The TPA will monitor the adequacy of its Network on an ongoing basis to ensure appropriate capacity to serve Participants in a timely manner and report to Employer at least annually on Network capacity. .
 - v. 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 Patient Centered Primary Care Homes (PCPCH).
- i. At a minimum, 65% of the Employer's group shall receive primary care services through 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 measure the PCPCHs performance using appropriate measures.

1. The TPA is encouraged to use performance measures that align with those being used to measure PCPCHs by the CCOs, accessible beginning on page 106 of the PCPCH Technical Assistance Guide, available at <http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf>.
- iv. The TPA shall hold PCPCHs accountable for performance.
 1. TPA shall produce regular PCPCH provider performance reports and share the results of those reports with the PCPCH.
 2. *TPA shall provide PCPCHs with opportunity to earn incentive payments determined by performance on identified quality measures. (optional)*
 - v. *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 coordinated, 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 coordinated 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 coordinated team-based care over the life of the Contract (Optional). Stronger alternatives to this language:*
 1. *TPA shall require all Network Providers to provide coordinated, team-based care (Extremely Aggressive)*
 2. *TPA shall require its Network Providers to provide coordinated, team-based care by Year 3 of the Contract (Very Aggressive)*
 3. *TPA shall have 75% of its Provider Network providing coordinated, team-based care by Year 3 of the Contract (Aggressive)*

4. *TPA shall have 50% of its Provider Network providing coordinated, team-based care by Year 3 of the Contract (Moderate)*
 5. *TPA shall have 25% of its Provider Network providing coordinated, 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 a web-based system, at a minimum, 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.
 - iii. The TPA shall monitor Network Providers efforts to implement patient activation by monitoring participation in training activities and use of standardized tools.
- 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 protocols 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.
 - 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.
 - 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 TPA shall adopt and utilize the set of standardized provider performance measures that are aligned with measures developed as part of a consensus process 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. apply clinical risk adjustment techniques when measuring provider performance and utilize socio-economic risk-adjustment techniques to the extent available.
 3. 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 Strategies

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:

- 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. Information Technology (IT)

- a. **Use of electronic health records (EHRs).** The TPA shall work with its provider network to increase the adoption and meaningful use of certified EHRs.³
 - i. The TPA shall require physicians across care settings to adopt and meaningfully use certified EHRs.
 - 1. Such providers shall further be required to implement processes to ensure data completeness and accuracy.
 - ii. *The TPA shall require all contracted providers, in addition to physicians, to adopt and meaningfully use certified EHRs. (Optional – Very Aggressive)*
 - iii. The TPA shall provide Participants secure electronic access to clinical health records, 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. **Electronic Health Information Exchange (HIE).** The TPA shall encourage physicians and hospitals within its provider network to exchange real-time electronic clinical information exchange across all care settings to facilitate care coordination among treating care providers, including those across organizational and technological boundaries. *Alternative language for more aggressive implementation follows.*
 - i. *The TPA shall require contracted physicians and hospitals to use real-time electronic clinical information exchange across care settings to facilitate care coordination among treating care providers, including those across organizational and technological boundaries. (Aggressive)*
 - ii. *The TPA shall require all contracted providers to use real-time electronic clinical information exchange across care settings to facilitate care coordination among treating care providers, including those across organizational and technological boundaries.. (Very Aggressive)*

³ See <http://oncchpl.force.com/ehrcert>

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. **Reporting Requirements.** The TPA shall provide regular reports to Employer to allow for assessment and monitoring of TPA performance to Contract requirements. Specifically, TPA shall provide Employer with reports on an agreed upon schedule using a reporting template and content approved by Employer on, at a minimum, the following areas of TPA performance:
 - i. Quality measurements, as described in Section V above
 - ii. Network Performance, including:
 - 1. Provider capacity and timely access to care
 - 2. Increase in PCPCHs within network
 - 3. Status of alternative payment model contracting across Network
 - iii. Cost Performance relative to sustainable rate of growth
 - iv. Service Utilization
 - v. Summary of Participant HRA results
 - vi. Annual analysis of opportunities and recommendations for improved quality and cost

- c. **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.

Payment reform matters

Better health, better care and lower costs

July 2016

Why payment reform is an important piece of the puzzle

Employers are the largest purchasers of health care in Oregon. Health care is expensive and it is of variable quality. Both nationally and in Oregon, there is a concerted focus on improving health care quality and outcomes while reducing cost growth. Payment reform is an important piece of the puzzle. Increasingly, in Oregon and elsewhere, Medicaid, Medicare and the commercial market are changing the way health care is paid for and moving toward alternative payment models that reward high value.

As self-insured employers look to rein in their health care costs, they too should look to implementing alternative payment models that move payment away from fee-for-service and toward models that create financial incentives for high-quality, efficient care. There is no one-size-fits-all approach to implementing alternative payment models. They may be implemented across an entire population, or can be focused on specific portions of the population. An employer can implement a number of alternative payment models within its population.

Payment reform ROI:

- CALPERS saved over \$30 million when it implemented a population-based payment model. These savings were due in part to large reductions (15 percent) in inpatient readmissions and inpatient days, as well as reduction in surgeries.
- Walmart participates in payment reform activities in Arkansas, including episode-based payments and PCMHs
- IBM participates in Vermont's PCMH program
- Intel developed an employer-sponsored accountable care organization based on a patient-centered medical home model that is based on shared risk and rewards

Paying for Outcomes and Health

Payment for care should be based on quality and health outcomes rather than on volume of services provided. The alternative payment methodologies described below represent a continuum of payment options that increasingly hold providers accountable for health outcomes — offering incentives for performance and quality outcomes, episode-based payment, and population-based contracting — and support better care and lowered costs. The intent is to increase the use of payment models that improve health outcomes.

See Page 2 for details on these payment models.

Pay for performance (P4P)

In P4P arrangements, providers are eligible to receive bonus payments based on meeting or exceeding performance targets on an agreed-upon set of performance measures. P4P continues fee-for-service payments, but gives providers some incentive to focus on quality outcomes and not just volume.

Patient-entered medical home payments

As described in the Patient-Centered Primary Care Homes fact sheet, a patient-centered medical home (PCMH) is a primary care practice that gives patients individualized care and support through a multi-disciplinary care team to help them stay healthy. In Oregon, PCMHs are referred to as patient-centered primary care homes (PCPCH). Typically, providers receive a per member per month (PMPM) payment on top of their existing fee-for-service payment to provide enhanced outreach, communication and coordination.

Through advanced practice models, providers develop patient-centered, multi-disciplinary team-based care for patients with multiple chronic conditions. PMPM payments for these types of practices are often significantly higher than for regular PCMHs. PCMHs are foundational elements to more advanced population-based contracting models.

Episode-based payments (also known as bundled payments)

Under this arrangement, a provider entity agrees to accept responsibility for the health of a patient relative to a particular condition or treatment in exchange for a set dollar amount that is expected to cover the total cost of all condition-specific services the patient needs.

Population-based contracting

Under this arrangement, a provider entity agrees to accept responsibility for the health of a group of patients in exchange for a set dollar amount that is expected to cover the total cost of care. If the provider is able to effectively manage costs and perform well on quality-of-care targets, then the provider keeps a portion of the savings generated. However, if the provider is not successful and delivers inefficient, high-cost care, then the provider may be responsible for the additional costs incurred over the expected total cost of care. The purpose of population-based contracting is to align the financial interests of providers with the interests of the patients, allowing for innovative approaches to patient-centered care, so that everyone wins if the patients are healthy and costs are contained.

An employer can implement population-based contracting by requiring its third party administrator (TPA) to enter into such contracts with providers in an effort to increase the number of insured lives covered by this type of contract.

Multi-state employers should participate in payment reform

Better health, better care and lower costs

July 2016

Payment reform works for multi-state employers

As the largest purchasers of health care in America, employers are paying a high price for care of variable quality. To control soaring costs, some employers — including those with employees in multiple states — are switching from the fee-for-service model to payment models that reward value.

Nationally, there is a movement away from the fee-for-service model, including in Medicare, Medicaid and the commercial market. Examples of payment models that are being implemented nationwide include pay for performance, payment for patient-centered medical home and care management programs, shared savings, episode-based (bundled) payment models, and population-based payments.

The coordinated care model includes various delivery system reform elements (e.g., patient-centered primary care homes, integration of physical and behavioral health) that can be aligned with payment that supports the particular activity. For example, additional payment could be offered to providers who become a patient-centered primary care home or to those providers reducing specific conditions (e.g., asthma, hospital care) for a specific population.

Examples of multi-state employers participating in payment reform

- Walmart participates in payment reform activities in Arkansas, including episode-based payments and PCMHs
- IBM participates in Vermont's PCMH program

Benefits of using alternative payment models

- Moves accountability for health outcomes and reduced costs to the providers
- Increases focus on quality outcomes
- Reduces incentives to over-utilize services
- Increases incentives to focus on employee engagement and coordinated care. Employees get the services they need when they need them, resulting in improved health outcomes and patient satisfaction

Patient-centered primary care homes

Better health, better care and lower costs

July 2016

Patient-centered primary care homes: good return on investment for employers

As the largest purchasers of health care in America, employers are paying a high price for care of variable quality. To check soaring costs, some employers are implementing payment models that reward high value.

There is emerging evidence that patient-centered medical home programs (both nationally and in Oregon) are yielding a good return on investment for employers.^{1,2} This brief provides more information about the patient-centered primary care home and highlights some of the early success of the medical home model in Oregon and in other national organizations.

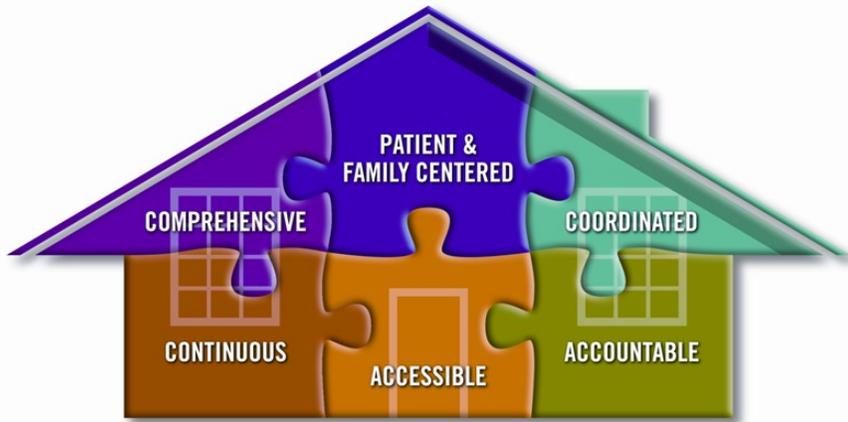
Benefits of a PCPCH

- Coordinated care to help employees get the services they need, when and where they need them
- Helps employees play an active part in their health
- Offers employees after-hours help and alternatives to the emergency room
- Drives down costs for employers by focusing on preventive care, wellness and managing chronic conditions

The Oregon way: patient-centered primary care homes (PCPCH)

A PCPCH is Oregon Health Authority's version of a "medical home," which is a primary care practice that gives patients the individualized care and support they need to stay healthy. In a medical home, the patient, the primary care physician, and a medical team work together to develop and implement a holistic plan of care for the patient. Primary care homes reduce costs and improve care by catching problems early, and focusing on prevention, wellness and management of chronic conditions. PCPCHs receive supplemental monthly payments on top of their traditional fee-for-service payment to provide this enhanced patient support.

Learn more about the PCPCH program at www.primarycarehome.oregon.gov.



Core Attributes of a patient-centered primary care home (PCPCH)

Across the nation evidence is emerging that patient-centered medical home programs are yielding a good return on investment in terms of employer costs and patient outcomes. If you are interested in learning about national case studies of employers [please see this article from the Robert Wood Johnson Foundation](http://www.bailit-health.com/articles/022613_bhp_paymentbrief_pcmh.pdf) at http://www.bailit-health.com/articles/022613_bhp_paymentbrief_pcmh.pdf.

Case Study #1: Metropolitan Pediatrics

Metropolitan Pediatrics has four locations in the Portland Metropolitan area. It first was recognized as a medical home by the PCPCH Program in 2011. In 2015 all four practice locations achieved the new PCPCH 3 STAR criteria for the most advanced medical homes. By investing in robust population health management tools, Metropolitan Pediatrics gained a better understanding of their patients' needs. For example, they found that asthma was the most common chronic condition, and then implemented the latest evidence-based asthma care guidelines. They added RN complex care management and an immunization improvement program. Through these efforts, they achieved a 28 percent decrease in ED costs, lower inpatient and admission rates for their asthma patients, and immunization rates 22 percent higher than the rest of Oregon.

Metropolitan Pediatrics continues to expand their medical home model through integrated behavioral health clinicians, dietitians, a new and better-connected electronic health records system, annual patient surveys, the creation of parent advisory committees for community outreach and enhanced access to after-hours care. They have fully adopted a team-based approach to caring for children and families, and continuously push themselves to provide the best possible care. In 2016 they will lead advancement of Pediatric services in a new direction with the implementation of Adverse Childhood Experiences (ACES) Resiliency training to focus on appropriate care and support of childhood adverse events.

Case Study #2: Winding Waters Clinic in Enterprise, Oregon

Winding Waters began their transformation in 2009 when they became part of the Safety Net Medical Home Initiative—a national patient-centered medical home demonstration to help 65 primary care safety net sites become high-performing medical homes—improving quality, efficiency and the patient experience. Their first steps toward transformation included increasing access through open-access scheduling, expanded hours, and implementation of a team-based model of care.

As a result of these early transformation efforts, wait times for follow-up appointments dropped from 12 days in 2009 to same-day access in 2015. Wait times for refill requests dropped from five business days in 2009 to two hours in 2015. And average scheduling wait time for physicals dropped from 36 days in 2009 to three business days in 2015. Additional data collected from 2008 to the present show a clear reduction in hospital visits (for Winding Waters patients) and emergency room visits (for all of Wallowa County). Hospital visits declined by an average of 7.25 percent per year over a six-year period (32.5 percent total reduction in utilization since 2008). ER visits declined by an average of 6.4 percent per year over a six-year period (28.7 percent total reduction since 2008).

(Continued on next page).

PCPCH core attributes

Accessible: Care is available when patients need it.

Accountable: Practices take responsibility for the population and community they serve and provide high-quality evidence-based care.

Comprehensive: Patients get the care, information and services they need to stay healthy.

Continuous: Providers know their patients and work with them to improve their health over time.

Coordinated: Care is integrated and the clinic helps patients navigate the health care system to get the care they need in a safe and timely way.

Patient- and family-centered: Individuals and families are the most important part of their practice. Care draws on a patient's strengths to set goals and communication is culturally competent and understandable for all.

How you can get started

1. Speak with your plan administrator about their experience with such programs. Most health insurers are now piloting or operating medical home programs.
2. If you have a large concentration of employees in one or more geographies, approach the largest medical group or health system that serves your population and ask about their experience with medical homes or PCPCHs, and their willingness to apply their program or develop a new one to serve your employees.
3. Participate in regional pilots.
4. Use a payment methodology that enhances payment to primary care practices.
5. Educate employees and dependents about the benefits of affiliating with and using a primary care provider.
6. Consider benefit modifications that provide incentives for use of a medical home.

Case Study #2: Winding Waters Clinic in Enterprise, Oregon (cont.)

These outcomes were achieved through use of an expanded team approach including care coordination, co-located and integrated behavioral health providers, and trained community health workers.

Winding Waters became a Tier 3 recognized Patient Centered Primary Care Home in 2012, and then became the first 3 STAR Patient Centered Primary Care Home in Oregon in June 2015. Winding Waters was awarded federally qualified health center status in August 2015, further ensuring sustainable service to the Wallowa County community.

Case Study #3: Michigan Demonstration Project to improve patient care

Through the Centers for Medicare and Medicaid Services, Michigan is one of eight states testing a patient-centered medical home across various payers, including employers and insurers. Nearly 1.8 million Michigan residents participate in this demonstration and receive coordinated, patient-centered care from physicians and health teams.

Primary care practices report improvements in the biggest health care challenges—obesity, diabetes, and hypertension. Adult patients in PCMH-designated practices had a 26 percent lower rate of hospital admissions for common conditions that could be addressed in a primary care setting.

Blue Cross-designated PCMH practices also had a 10.9 percent lower rate of adult emergency room visits and a 22.4 percent lower rate of pediatric emergency room visits for common chronic and acute conditions such as asthma. Blue Cross estimates that it has saved \$512 million through disease prevention, reduced hospitalizations and emergency room visits, and management of acute and chronic medical conditions.

Improvements resulting from the PCPCH Program

Almost 600 primary care homes are recognized statewide, representing more than 50 percent of all eligible clinics in Oregon and serving over 2 million Oregonians, more than half of the state's population.

1. A 2013 survey of PCPCH recognized clinics found that 85 percent of practices feel that PCPCH model implementation is helping them improve the individual experience of care and 82 percent report the model is helping them improve population health management
2. Over time clinics recognized as PCPCHs showed a significant increase in preventive procedures and a significant reduction in specialty office visits as compared to non-PCPCH clinics.
3. In a recent report from the Oregon Health Care Quality Corporation that compared PCPCH recognized to non-recognized clinics, there were significant measure performance improvements in diabetes HbA1C and LDL-C; diabetes kidney tests; diabetes eye exams; adolescent well care visits; and Chlamydia screening. The report is available at: http://qcorp.org/sites/qcorp/files/qCorp-statewide-report-2015-postpress-corrected-singlepages_WEB-FINAL_percent20BBF_percent202.pdf.

Citations:

1. M. Nielsen, A. Gibson, L. Buelt, P. Grundy, K. Grumbach. The Patient-Centered Medical Home's Impact on Cost and Quality.
2. Oregon Health Authority. Patient-Centered Primary Care Home Program 2014-2015 Annual Report.

Finding a Coordinated Care Health Plan for Your Employees

Coordinated care shows strong potential to improve health while also controlling health care costs. A growing number of Oregon carriers are offering coordinated care plans; other plans can be modified to include it.

To determine whether your current plan or one you're considering uses elements of coordinated care, walk through this checklist with your broker or carrier. The more boxes you check, the more the plan aligns with coordinated care. For more details on any of these elements, please see the Framework document or the Model Contract included in the Toolkit or available on line at <http://www.oregon.gov/oha/OHPR/Pages/2014-Coordinated-Care-Model-Alignment-Work-Group.aspx>.

Choice and responsibility

- The plan offers programs to help employees engage in their health care (e.g., reduced cost sharing for engaging in positive personal health behaviors).

Transparency

- The plan shares information with providers (following privacy regulations) to help them better care for their patients.
- The plan publishes information on its provider network's quality performance and costs.

Controlled costs

- The plan has an expected rate of cost growth and a plan to manage and limit this growth while ensuring high quality care.

Paying for value and good health

- Providers are compensated based on their performance in terms of improving health outcomes (not based on volume of care).
- The plan works with its provider network to focus on evidence-based practices that show good results.

Effective care

- The plan makes efforts to integrate physical and behavioral health care and to treat an individual as a whole person rather than separate parts.
- The plan helps primary care physicians transform their practices to be Patient Centered Primary Care Homes (PCPHs).
- The plan supports effort to transform the healthcare system and increase support of primary care.
- The plan encourages providers to collaborate and share clinical information in real time to make treatment more effective.
- The plan requires physicians to use electronic health records.