This document contains clarifying questions posed by CCOs in an email dated July 19th, 2018 regarding CCO 2.0 potential policies posted to OHA's CCO 2.0 website and responses from the Oregon Health Authority.

Goal #1: Partnering with communities to support health and health equity

Question:
Policy #3: The overall goal here is to "increase strategic spending by CCOs on health related services". This seems redundant to Policy #1, which is implementation of the legislatively approved requirement that CCOs spend "a portion of the annual net income or reserves of the CCO that exceed [financial solvency requirements]" on services to address social determinants of health. Many investments in social determinants of health are health related services expenditures—either flexible services or community benefit initiatives. Are we misunderstanding the purpose of Policy #3?

Response:
While health-related services (HRS) can be one of the mechanisms to satisfy the social determinants of health and health equity spending requirements in policy #1, another key component of policy #1 is that CCOs will be required to hold contracts with—and direct a portion of the required spending to— partners that help them improve their members' social determinants of health, through a transparent process. HRS would not be applicable in these circumstances.

The intent of policy #3 is to ensure that HRS community benefit initiatives align with community priorities (such as those in the CCOs' Community Health Assessments and Community Health Improvement Plans), and that CCOs' HRS policies include a role for the Community Advisory Council in making decisions about how community benefit HRS investments are made. These components are not included in policy #1; therefore, the two policy options are not duplicative.

Question:
Policy #8: Does OHA intend to identify the "best practices to outreach to culturally specific populations (BH)"? Also, is the intent that this requirement would only apply to members seeking behavioral health treatment?

Response:
OHA's Office of Equity and Inclusion will identify the best practices to outreach to culturally specific populations. The intent is that all Oregonians would know how to access behavioral health care.

Goal #2" Providing equitable, patient-centered care

Question:
Policy #3: What does "Clear ownership of BH benefit by the CCO" mean?

Response:
It is the expectation of OHA that CCOs be fully accountable for the behavioral health benefits of their members as described in their contracts and not fully transfer the benefit to another entity. This includes ensuring an adequate provider network, timely access to services, and effective treatment. The CCO needs to be fully accountable for these responsibilities.

Question:
Policy #8: How does OHA envision that CCOs would demonstrate "prioritiz[ing] access to BH early intervention (0-5) and BH prevention services for children"?

Response:
Prioritize access to Social-Emotional developmental services, health services, early intervention and targeted supportive services, and behavioral health treatment for children ages birth through five years. This includes integration and co-location of services, screening, and prioritizing assessments and treatment for this population.

Question:
Policy #10: How does this policy ("Require CCOs support EHR adoption across behavioral, oral, and physical health contracted providers") relate to Policy #1 ("Develop an incentive program to support behavioral health providers' investments in electronic health records")? What does "support" mean in

Response:
Policy #1 This incentive program would be developed and operated by OHA, if funding is approved by the Oregon legislature. CCOs would participate in developing priorities for how to distribute limited EHR incentive funds among licensed behavioral health agencies, to ensure that local community priorities inform the behavioral health EHR incentive program.

Policy #10 enhances a current CCO contract requirement to "support EHR adoption" by specifying that CCOs must provide support for EHR adoption across behavioral, oral, and physical health contracted providers. This would work best for behavioral health providers if OHA is able to provide incentives under Policy #1, but CCOs have a role to play in supporting EHR adoption regardless of whether there are incentives available. OHA does not define "support" explicitly. EHRs are foundational for increased and/or improved care coordination and CCOs can play a role in improving EHR adoption and use. In order to determine how to best support contracted providers, CCOS will need to gain an understanding of their provider environment, including what providers are currently using, and what providers might need, and what opportunities exist. Supporting EHR adoption could include, but is not limited to, financial support, technical assistance, sponsoring learning collaboratives, or support for other

opportunities such as group EHR purchasing or shared technical staff. CCO support provided should be informed by local needs, resources, and priorities.

Question:
Policy #11: What does "ensure" mean in the sentence "Require CCOs ensure behavioral, oral, and physical health contracted providers have access to technology…"?

Response:
Policy #11 enhances a current CCO contract requirement that CCOs "support health information exchange," by specifying that CCOs must ensure behavioral, oral, and physical health contracted providers have access to the health information technology (HIT) tools they need to electronically coordinate care across care settings for patients. CCOs should consider: how are physical, behavioral and oral health providers currently coordinating care with each other when they have patients in common? What is the roadmap for ensuring providers in a CCO's region to have the tools needed to coordinate care, including sharing patient information across care team members? To do this, CCOs must understand the provider HIT environment, including what technologies providers are currently using, what technologies providers might need to improve care coordination, what opportunities might already exist that can be leveraged, and where can the CCO's efforts best be targeted. At a minimum, CCOs should ensure that tools are available for providers use, but CCOs should also have strategies to support and encourage their contracted providers' adoption and effective use of electronic health information exchange methods. Some ways CCOs could address access and effective use include, but are not limited to, financial support for technology or technical assistance, educating contracted providers on the various technologies available to support health information exchange, providing technical assistance around clinic work flows and use, extending CCO technology contracts to their contracted providers, and holding learning collaboratives for contracted clinics to encourage care coordination and inform providers of accessible HIE tools.

Question:
Policy #12: How does this policy ("Develop mechanism to assess network adequacy services across the continuum of care…") relate to Policy #6 ("Require CCOs to report on capacity and diversity of the medical, behavioral, and oral health workforce…")? Are they redundant?

Response:
Policy #6 is specific to reporting on the capacity and diversity of the workforce. Policy #12 is specific to ensuring that there is a full continuum of behavioral health care available to members, from prevention to residential treatment. These policies are linked and complement one another.

Question:

Policy #15: What does this mean? Is OHA envisioning incentive payments or free CMEs or something else?

Response:

This policy option has been revised to "CCOs, with the support of OHA, require providers to implement trauma informed care practices." OHA is not envisioning incentive payments or free CMEs, but rather a documented plan.

Question:

Policy #16: What does this mean? Is it about telemedicine or tele-mentoring? Or mobile apps designed for member engagement?

Response:

Policy Option #16 is about the continued CCO role in supporting the use of HIT for patient engagement by the CCO and/or their contracted providers. Patient engagement in their own health care through HIT can happen in many ways, and should align with a CCO's priorities for improving their members' health outcomes. Examples of HIT that CCOs have considered for patient engagement include providing smart phones to patients, telemedicine, mobile apps for member engagement like Text4Baby, using community health workers or others to promote electronic access to a patient's own information and for provider-patient interaction (like patient portals attached to a providers' electronic health record), education campaigns to providers or patients around the value of accessing full clinician notes through patient portals (a movement called Open Notes, with high adoption across Oregon), etc. Telementoring would not fit into this policy option if it is solely provider-to-provider telementoring. If the telementoring was provider-to-patient, such as health coaching services offered via email exchange between provider/health coach and patient, that would be patient engagement.

Goal #4: Paying for outcomes and value

Question:

Policy #3: What does OHA mean by "capacity management" and who would perform the assessment? Is this statewide, by county, or by CCO service area?

Response:

This policy option is being removed.

Goal #5: Financial sustainability and strategic investment

Question:

Policy #3: How does this relate to or interact with the rule advisory committee scheduled for July 30 on "CCO Financial Reporting Requirements" in OAR 410-141-0340?

Response:

This policy is related to improving and changing financial reporting in CCO 2.0 and moving to a standardized format (i.e. NAIC). The rules proposed for 2019 (OAR 410-141-0340) primarily focus on sub-capitated entity reporting, and clarifying financial reporting for the extension year. The proposed 2019 rules are built to be applicable in the future no matter the reporting format chosen in CCO 2.0. (Proposed rule changes and notice of a rules advisory committee are attached if needed)

Question:
Policy #4: What is the problem OHA intends to solve by "creat[ing] a statewide reserve pool in addition to CCO-specific reserve requirements in the event of insolvency"?

Response:
OHA believes moving to a standardized framework for financial reporting will improve the transparency and solvency assessment of each CCOs in the next contract. However, using a framework such as NAIC/RBC may also increase the reserve requirements. A statewide reserve pool is one approach to address possible increases in reserve requirements rather than funding such increases through CCO capitation rates.

For questions about this document, requests for alternative formats or more information please contact Jeff Scroggin at jeffrey.scroggin@dhsoha.state.or.us or 541-999-6983