CHILDREN'S HEALTH *alliance*

June 4, 2018

Patrick Allen, Director
Dana Hargunani, Chief Medical Officer
Oregon Health Authority
500 Summer St. NE E20
Salem, OR 97301

Dear Director Allen and Dr. Dana Hargunani,

Thank you for the opportunity to provide feedback as you seek to build the second iteration of the Coordinated Care Organizations (CCOs) in Oregon. The creation of the CCOs have allowed for innovation and investments that could not have taken place without the vision of the legislature and OHA in creating regional community-based organizations that serve the specific health care needs of the community. While great strides have been taken, the Children's Health Alliance (CHA) believes that there are opportunities for additional improvement in the structure and policies of the CCOs.

The Children's Health Alliance (CHA) is a 501(c)3 organization consisting of over 120 private practice pediatricians across 22 practice sites in NW Oregon and SW Washington. CHA practices are recognized by the Oregon Health Authority as Patient-Centered Primary Care Homes and serve as national leaders in pediatric population health management. Formed with the guiding mission to improve health outcomes for children, CHA fosters a strong culture of quality improvement and patient-centered medical homes for approximately 140,000 children, including over 35,000 OHP and CHIP recipients.

The Children's Health Alliance held their Annual Member Meeting on May 15, 2018. We were grateful to have Dr. Hargunani as our keynote speaker. During that meeting, input for CCO 2.0 policy development was solicited from 60 pediatric providers. Below is a summary of the recommendations that emerged from the group during and after this discussion.

Behavioral Health Integration

Invest in Comprehensive Behavioral Health for Children
CCOs can advance behavioral health by working with pediatric clinics to use data-based decision making to determine where to place the most needed services. Payment streams should allow behavioral health clinicians in primary care to bill for the full spectrum of services offered, including mental health codes, in a manner that is seamless to both the provider and patient. Barriers to receiving needed services should be reduced, allowing patients to access care wherever it is sought.

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CCOs should recognize that primary care behavioral health delivery looks different in pediatric-care settings than it does in adult-care settings. . While adult care may focus more on behavioral services linked to a medical condition, pediatric behavioral health has a strong focus on preventive care, early intervention, and parent education and support. Payment should include behavioral health services that do not require a "physical" or "mental" health diagnosis; current FFS payment mechanisms require behavioral health issues to be severe enough to have a diagnosable disorder before services are paid by health plans, which limits access to needed preventive care. This small investment in services will have significant long-term benefits, helping to mitigate the potential need for more complex services downstream. Per-member-per month (PMPM) payment mechanisms for behavioral health services should appropriately recognize and incentivize providers to work across systems (schools, DHS, and others), increase the capacity of the medical providers to provide behavioral health services, and ensure the appropriate mix of screening and interventions are followed to meet the needs of the patient.

Behavioral health integration at CHA pediatric practices occurs when patient and population behavioral health needs can be identified through effective screening and evidence-based practices can be delivered on-site. Integration of behavioral health into primary care can take place in many forms and must be allowed to meet the needs of the patients served by the primary care office. Services should exist on a continuum so that practices can provide a "menu" of services that are integrated into the clinic at a variety of levels as opposed to a "one size fits all." For example, funding early childhood mental health prevention and programming that involves weaving programming into well-child visits would help ensure that all parents have a foundation in evidence-based parenting practices without having to wait for concern to develop.

Modernize Contracting Structures

CCOs are paid on a global budget. Siloed sub-capitation payments, especially to behavioral health, should be discouraged. These sub-capitation, and/or "carve-out" arrangements increase administrative burden, limit network adequacy, restrict access to behavioral health services in the primary care medical home, and make it more difficult for patients to access the needed services in a manner that meets their needs.

Pre-authorizations and other barriers to timely access to care should also be eliminated or reduced so that behavioral health clinicians can make direct referrals to specialists or complete evaluations when clear indicators are present that additional evaluation and testing is needed. Similarly, permitting behavioral health clinicians to refer directly to services such as System of Care Wraparound Services would permit youth to access care without having to go through the Emergency Department.

The level of integration of behavioral health services with physical health services should be measured at the CCO-level and community level. This might be represented by how many administrative functions, operational policies, utilization management, and payment systems are shared among service lines that previously have been paid separately.

To date, many CCOs have failed to coordinate and blend service lines. A health care provider organization should be able to contract directly with a single CCO for services it chooses and is licensed to provide. Primary care and behavioral health clinicians at the same practice should be included in the same contract and undergo the same credentialing process. The provider should be able to use code sets that support services they provide and have a single CCO payer to work with, not multiple entities.

Coordination and Communication of Behavioral Health Services
One of the most significant barriers to patient-centered care that crosses the continuum of services received by patients with behavioral health needs is the coordination and communication of services between primary care and community-based behavioral health clinicians. Information that is crucial to patient care, coordination, and safety should be communicated timely and appropriately. CCO 2.0 should require the coordination of services and timely communication of health information between all providers of care, including school-based health centers, DHS, and others. This could be accomplished through the development and implementation of a (pediatric-focused) universal referral/information exchange form to standardize and encourage two-way communication between primary care and community-based behavioral health clinicians, similar to the *Early Intervention/Early Childhood Special Education Universal Referral Form for Providers*.

CHA providers agree with OHA's recommended strategy that care coordination should be required for all children in Child Welfare, state custody and other prioritized populations.

Measurement of Integration
Behavioral health services for the primary care population should be encouraged to exist on a continuum, allowing practices to provide a "menu" of services that are integrated into the clinic at a variety of levels as opposed to a "one size fits all" model of services (i.e. either co-located or short-term brief interventions). This definition allows for the variance in how clinics implement screening and interventions. For example, at some sites this might mean training medical providers to deliver brief interventions whereas at others this may include more involvement from traditional behavioral health providers; however, if the key components are met (adequate and appropriate screening paired with options for behavioral health service delivery) then the population needs are addressed.

As such, measurement of integration should recognize that different models exist to meet the needs of the practices. OHA should convene a workgroup to identify appropriate measures for the pediatric population that includes population reach, process measures serving specific populations (anxiety/depression, ADHD, etc.), and outcome measures. These measures should include input from behavioral health clinicians to identify applicability and feasibility to outcomes desired from services offered. It is important to include measures of intervention/treatment fidelity as a part of evaluating efficacy of measures.

When the patient is referred to community-based behavioral health clinicians, metrics to track and record timely access to services, appropriateness of services, and follow-through on referrals to the network should be maintained and improved upon.

General
In 2015-2016, the Children's Health Alliance helped convene a multi-disciplinary workgroup to explore the existing barriers to integrating behavioral health care in primary care practices and identify attainable solutions. As a result of this work, an issue brief was developed that proposes solutions to address the same issues as OHA in its work to further integrate behavioral health services for its OHP members. This brief is included along with this letter for reference.

Social Determinants of Health

"The right care in the right place at the right time for the right person."
We recommend that CCOs cover services wherever they are provided so that families can get the care they need in the places that are easiest for them to access it. This includes increased investment in home visits, community health workers, and peer supports who mirror the communities that they serve. CCOs should work closely with the primary care offices to break down barriers to receiving care, which may include language/translation services, transportation, extended office hours, encouragement of services provided in the primary care medical home, health literacy and food insecurity, among others. CCO care coordination services should coordinate closely with primary care offices to identify and share information about challenges for patients and families so that barriers to care are addressed among all care team members.

CHA providers support continued investment in school-based health centers, as an easily accessible location to serve families. This investment, however, must be accompanied by coordination of care with primary care providers to ensure all care team members have updated information on the plan of care and needs for collective patients.

Invest in Home Visiting Programs
Home visitation programs have demonstrated success in improving child and family outcomes in areas such as: Child and Family Safety and Stability, Maternal and Child Health, and Early Childhood Development. Home visits by a nurse, social worker, or peer can also reinforce and extend positive parenting and resilience strategies that pediatricians teach families during office visits, while also connecting patients and their families to community resources and supports.

Translation Services
CHA recommends that CCOs provide translation services of all languages to ensure that language is not a barrier to access and delivery of care. This includes translation services for scheduling, provider visits, follow-up care, and nurse advice lines.

Value-Based Payments

The opportunity to participate in value-based payments (VBPs) and incentives is critical to the support and sustainability of patient-centered primary care homes. These investments should value the work provided at the medical home and support the provision of the full spectrum of services offered to meet the needs of patients. In particular, the VBP and per-member-per month (PMPM) payments need to support care coordination services in primary care clinics, including non face-to-face offices visits that can lead to improved and more efficient care. Primary care transformation goals include delivering care that is most efficient and patient-centered, moving beyond the model of strictly providing care in an exam room. In addition, VBPs need to incentivize and value the services offered to meet the needs of specific populations, such as pediatrics.

Value of Child Health Services

While contracts are still tied to FFS payment of services delivered, the prioritized list should consider better alignment with child health goals and preventive services. The Health Evidence Review Committee (HERC) should be required to have members that have knowledge of child health. Currently, pediatric topics are a very small minority of topics chosen for review. In addition, the prioritized list should be reconsidered for children under the age of 6, when prevention and early identification of risk is critical to the future health of the population and diagnosis of conditions may not yet be readily available.

Rate Setting to Consider VBPs and Efficiencies

The current rate setting process (based on the historic fee for service payments) limits transformation to value-based payment, leads to high variability year to year and high variability between CCOs (often in the same geographic area). There are already rate groups that have different payment rates to account for different utilization and population mix. Risk adjustment methodologies based solely on medical complexity have limited applicability to pediatrics and should not be applied to rate setting process. CCOs should not be penalized for efficiency of care delivery by lowered rates in subsequent years. A single rate structure for all CCOs would limit this consequence.

Medicaid Re-enrollment

High rate of delays in re-enrollment affects the ability for members to receive health services and meet goals towards quality measures. Providers need to know their patients on a timely basis to appropriately manage the health of their assigned population. The re-enrollment process should be streamlined and improved to limit gaps in coverage for OHP members.

Measurement and Accountability

Performance incentives incorporated into VBPs should encourage the appropriate areas of focus, ensuring all populations are covered. What is measured becomes an area of focus and

investment, so metrics should be carefully chosen to reflect the priorities of OHA. Unintended consequences of metrics should be carefully considered before finalizing and holding providers accountable. CCOs need to recognize areas that can be managed and improved upon at the clinical level and adjust associated benchmarks and expectations of providers according to social determinants of health and overall risks of the population.

Health complexity
VBPs should take into consideration the health complexity of the patient, including medical *and* social complexity, especially when considering payments to primary care offices. The support level needs at the primary care office increase significantly when social complexity is present.

Data transparency
Providers need access to data on a timely basis to effectively manage their population. The CCOs should ensure timely data transparency between CCOs and primary care providers, including utilization, cost of care, and patient complexity.

We appreciate the opportunity to provide feedback to the Oregon Health Authority during this important evaluation process. We look forward to participating in further discussions and are happy to provide clarification for any of the information above.

Sincerely,

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