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.