OCHIN
CCO 2.0 Recommendations
April 13, 2018

As a public-private partnership and Health Center Controlled Network supporting, largely, the safety-net clinic population in Oregon but also non-FQHC clinics, we would like to offer a response to the policy options put forth in CCO 2.0. I responded to the CCO 2.0 survey, but also wanted to provide our recommendations directly:

Value-Based Pay

We recommend that CCO 2.0 should be increasingly coordinated with the OHA's Alternative Payment and Care Model (APCM, i.e. capitated Medicaid wrap payment to FQHCs). The Oregon APCM program has already begun a shift to increased accountability, which is an area highlighted by OHA as newer for CCO 2.0. We believe that an end goal should be more shared strategy, learnings, objectives, and alignment between CCO-based and APCM-based payment transformation efforts. This would also provide an improved measurement path by aligning quality measure requirements and reduce administrative costs associated with quality reporting.

Social Determinants of Health

We recommend OHA focus on global budgeting at the CCO level to encourage cross-sector partnership (health and social services) to yield the outcomes sought. We also recommend OHA align strategies to address SDH with existing capabilities in the EHR. Regarding VBP focused on SDH, we question the ability to successfully incentivize outcomes by addressing SDH without more data to understand: collection of SDH data at the individual level, aggregation of SDH data across sectors at the individual level, and addressing SDH in the health care setting. We believe that OHA must address this need for data systematically and recommend cross-sector partnership to gather individual-level SDH and outcome data. In response to the SDH policy options, we recommend focusing investment on infrastructure connecting social and health services in order to address SDH in two ways: 1) physical connection between social and health service organizations (e.g. embedding case workers in primary care, nurses in social service delivery sites) 2) electronic connection between social and health service organizations following national frameworks for data exchange. We believe in metric development to support addressing SDH but question the effectiveness of addition of SDH-specific metrics to CCO incentive metrics as an approach to addressing SDH without the above (e.g. addition of a screening metric).

Behavioral Health Integration

We recommend OHA emphasize the need for data exchange and interoperability between behavioral/mental health and primary care. NAMI has found that patient outcomes improve when interoperability between behavioral/mental health and primary care increases. There are two specific areas we suggest OHA focus when emphasizing interoperability: 1) Working directly with behavioral/mental health providers to socialize and incentivize interoperability with primary care and 2) Eliminate financial barriers to interoperability and support adoption of national interoperability standards.

Cost Containment

We recommend OHA look to electronic methods of data exchange and care delivery to contain cost long-term as well as limit administrative burden associated with quality reporting by aligning quality-incentive programs and reporting where appropriate. We recommend measure alignment consider: feasibility of measurement in electronic systems, gaps in sector-specific measurement, and gaps in cross-sector measures at the CCO level.

Thank you for the opportunity to provide feedback. We look forward to participating in further discussion over the coming months and would be happy to clarify any of the points above.