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 (OEBB), 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 CCOs[1] 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 OEBB. In 2015 contracts with eight health plans, PEBB required the plans to include CCM elements in their health benefit offerings. The forthcoming OEBB 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 OEBB 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 carriers[3] and seven large employers[4] 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	• 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	• State agency employees • University employees • Lottery and semi-independent state agencies	• 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	• 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: • 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	• Age: – 43% are children – 40% are adults – 13% are aged • Gender: 59.8% are female	• Mean age is 48.6 • Gender: 57.5% are female • Race/ethnicity: 4% are Latina/o	• Mean age is 47.5 • Gender: 74.8% are female • Race/ethnicity: 4.6% are Latina/o	• Age: – 12.7% are between 18-34 – 28.1% are between 35-54 – 25.4% are between 55-64 – 33.7% are 65 and older

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	Oregon Health Plan	**Public Employees' Benefit Board (PEBB)**	**Oregon Educators' Benefit Board (OEBB)**	**Commercial**
	• Race/ethnicity: – 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)			• Gender: 59% are female • Race/ethnicity: – 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	• 64.7% of Medicaid BRFSS (MBRFSS) respondents have a chronic disease • 36.8% of MBRFSS respondents are depressed • 56% of MBRFSS respondents had limited activity due to poor health[5]	• 15.5% of PEBB BRFSS respondents are limited in activities due to physical, mental, or emotional problems • 46.2% of PEBB BRFSS respondents have a chronic disease[6]	• 14.7% of OEBB BRFSS respondents are limited in activities due to physical, mental or emotional problems • 47.4% of OEBB BRFSS respondents have a chronic disease[7]	• 21.3% of BRFSS respondents stated that they are limited in activities because of physical, mental, or emotional problems • 61.5% of BRFSS respondents are at risk for chronic disease[8]
Socio-economic factors	• 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 MBRFSS respondents are food insecure • 22.3% of MBRFSS respondents are more likely to be hungry	• Household income: – 20.3% of PEBB BRFSS respondents make $25,000 to less than $50,000 – 77.9% of PEBB BRFSS respondents make $50,000 or more • Educational attainment is high (71% graduated college and	• Household income: – 24.1 % of OEBB BRFSS respondents make $25,000 to less than $50,000 – 69.1% of OEBB BRFSS respondents make $50,000 or more • Educational attainment is high (71% graduated college	• Household income: – 59.8% of all BRFSS respondents (including those who might have coverage listed to left) make less than $50,000 – 40.3% of all BRFSS 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) • 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 co-payment for certain types of outpatient services and a $1 or $3 copayment for certain prescription drugs (unless they are exempt)	• Kaiser OOP max– $600/person, up to $1200/family • All other plans OOP max – $1500/person, up to $4500/family	• Kaiser OOP max – ranges from $1500- $5000/person, $3000-$10000/family • Moda OOP max – ranges from $2400-$5000, $7200-$12,700/family	• 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)	• Individual and small group benefits are based on the Essential Health Benefits benchmark plan selected by the state – 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 (OEBB)**	**Commercial**
Participating carriers	• 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-	• 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	• Moda Health Plan covers • 104,695 subscribers and dependents • Kaiser Permanente of the Northwest covers 24,700 subscribers and dependents	Individual (I), small group (SG), and large group (LG): • 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	• Social Security Act Title 19 and Title 21 • July 2012 1115 Waiver Demonstration	• Oregon legislature (ORS 243.061 to 243.145 • PEBB Board • Collective bargaining	• Oregon legislature (ORS 243.860 to 243.886) • OEBB Board • Collective bargaining	• 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/MBRFFS%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 your 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?