Coordinated Care Organizations (CCOs) and Behavioral Health Services

Oregon State Legislature House Committee on Behavioral Health

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Presentation Overview

- CCO 101
- Coordinated care across the behavioral health system
- Balancing workforce needs, contract expectations, and rural realities
- Opportunities ahead
- Q&A

CCO 101

Jeremiah Rigsby, Chief of Staff

Columbia Pacific CCO, Jackson Care Connect CCO, and Care Oregon

CCO 101

- CCOs contract with the Oregon Health Authority to coordinate delivery of the Oregon Health Plan benefit
- The Triple Aim
  - Better care and outcomes
  - High quality patient experience
  - Lower sustained costs
- Hub and spokes model
- Local accountability and local control
- Defining "integration"
- Working towards a "global budget"

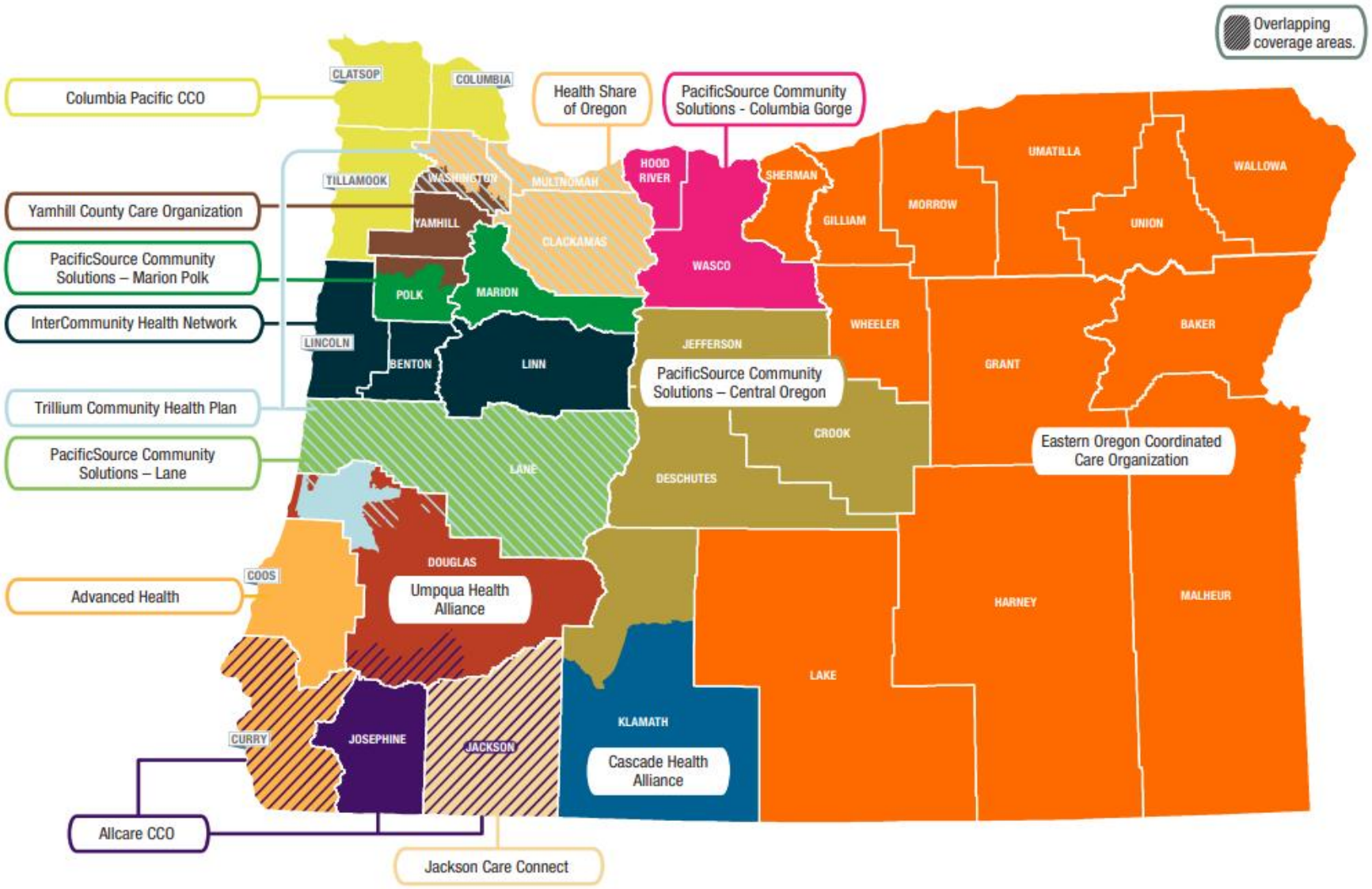
The first five years

- Community Advisory Councils (CACs)
- Convened community stakeholders to develop Community Health Improvement Plans (CHIPs) and Community Health Assessments (CHAs)
- CCO Incentive Metrics in addition to other measures
  - Depression screening
  - Emergency department utilization for members with severe and persistent mental illness (SPMI)
  - Follow up after emergency department visit for mental health
  - Screening, brief intervention and referral to treatment (SBIRT)
- Maintained cost of care growth rate of 3.4%
- Established networks at the regional level
- Decreasing avoidable emergency department (ED) visits and hospital admissions for people with chronic disease
- Electronic health record (EHR) provider adoption and utilization

Current CCO service areas

Coordinated Care Organization 2.0 Service Areas

Oregon Health Authority



CCO 2.0

- New contracts effective January 1, 2020
- Five-year implementation plan
- Priority areas as identified by Governor Brown:
  - Focus on social determinants and health equity
  - Increase value and pay for performance
  - Improve the behavioral health system
  - Maintain a sustainable cost growth
- CCO enrollment currently represents about 1.2 million Oregonians

Coordinating care across the behavioral health system

Athena Goldberg, Vice President of Behavioral Health Services, AllCare Health CCO

CCO 2.0 behavioral health goals (some)

- CCOs cannot fully contract-out the OHP behavioral health benefit
- Annual reporting on the capacity and diversity of the workforce in parity with OHP membership
- OHA to address billing and policy barriers to integration including increased technical assistance to CCOs and providers
- CCOs coordinate care for members with certain mental health disorders, in foster care, and those in medication assisted treatment
- Annual Comprehensive Behavioral Health Plan (CBHP) in collaboration with regional stakeholders – first plan is due July 2021

Care coordination and integration across CCOs

- CCBHCs: Certified Community Behavioral Health Centers
- PCPCHs: Patient Centered Primary Care Homes
- Behavioral Health Homes
- IIBHT: Intensive In-home Behavioral Health Treatment
- Wraparound and Systems of Care
- Memorandum of Understandings (MOUs) between Community Mental Health Programs (CMHPs) and CCOs; Collaborate on implementation planning and the Community Health Improvement Plan (CHIP)
- Peer Support Services and other Traditional Health Workers types

Additional challenges to delivering care

- Housing
- Workforce
- Lack of overall system cohesion and a statewide plan
- Transportation
- Complicated guidance and rules
- Fee schedules and reimbursement
- Balancing accountability and provider reporting burden
- Care continuity across acute care and the corrections system

Balancing workforce development needs, contract and pandemic expectations, and rural realities

Henry T. O'Keeffe, General Counsel

Greater Oregon Behavioral Health, Inc.

Workforce development

- Providing high-quality community-based behavioral health services is relentless work, particularly now
- Recruitment and retention of licensed staff is particularly hard in Oregon's rural and frontier communities
- The salaries offered through Medicaid reimbursement don't align with the corresponding education requirements
- People's experience and credentials are portable both inside and outside of rural and frontier communities
- Providers have more earning potential in private practice than public service, and wage compression impacts all provider types
- System capacity shortages (such as at the State Hospital or in the acute care context) increase the likelihood of providers experiencing burnout and, in some cases, even physical harm

Contractual and pandemic pressures

- While the system must create accountability, excessive reporting burdens necessarily result in time and money directed away from OHP member care
- In the context of managed care, a program's ability to adequately scale is often stifled by the relatively low enrollment numbers indelible to rural and frontier communities
- Additional funding tends to follow the establishment of new benefit programs; but those programs are often underfunded (e.g., ABA and IIBHT)
- Oregon's rural and frontier communities often lack sufficient prescribers and other credentialed individuals to fill key roles in the behavioral health delivery system
- Social isolation and other factors related to the global COVID-19 pandemic have increased the need for and utilization of behavioral health services throughout Oregon
  - In the past 12 months, the number of behavioral health encounters has vastly exceeded the number of physical health encounters
  - While the ability to provide additional telehealth services has truly been a game-changer, it has not been without its challenges for low-income Oregonians with severe and persistent mental illnesses, or the providers serving them

Some potential solutions

- Behavioral health workforce development must be at the front end of any discussion in Oregon about healthcare resources
- Additional funding should be allocated for educational programs assisting with the local development of licensed behavioral health staff
- In addition to loan forgiveness programs, higher salaries are needed to encourage people to remain in their positions after their loans are paid down/off
- CCOs need help instituting and continually financing "exceptional rate" payments and incentives for long-term contractual arrangements with local providers
- When additional OHP benefits are added in the future, they must be fully funded, and the requirements surrounding existing benefits examined for potential cost savings

Opportunities ahead

Bill Bouska, Director of Government Relations

InterCommunity Health Network CCO

Needed community investments

- This is a system problem that requires a multi-level system solution
- Move more funding into community-based behavioral health services
- Must address housing and workforce
- Strategically braid current funding opportunities from 988, the opioid settlement, Measure 110, and the American Recovery Plan Act (ARPA) into current funding streams
- Statewide capacity investment and regionalized funding tied to increasing access, cross system accountability, and meaningful outcomes

§1115 Medicaid demonstration waiver renewal

- Populations in jail / detention, Oregon Youth Authority (OYA), and the Oregon State Hospital (OSH)
  - Maintain CCO enrollment during pre-adjudication for those in jail / detention
  - Create a care coordination only plan or enrollment category for CCO members
  - Ensure jails are utilizing PreManage and that eligibility files remain open across Medicaid data systems
- Peer delivered services
  - No longer require service requests be tied to a treatment plan
  - Revisit requirement for clinical supervision for providers that are part of a care team
  - Remove barriers created by Certificate of Approval (COA) processes
  - Ensure community-based organizations (CBOs) are eligible for contracts

How CCOs can help

- Behavioral health identified as a high priority in 2020 CCO 2.0 contract
- Years invested have fostered regional relationships and increased health system transformation
- Local accountability and local control
- CCOs convene regional providers, partners, and stakeholders to identify system strengths, gaps, and needs
- State leadership and innovation will always be necessary for aspects of the system

Questions?

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