



March 2, 2017

The Honorable Governor Kate Brown
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Dear Governor Brown:

On May 30, 2016, Representative Mitch Greenlick, Chair of the Oregon House Healthcare Committee, formally requested that the Oregon Health Policy Board (OHPB) provide independent policy guidance to the Legislature and the Oregon Health Authority regarding the future of coordinated care organizations in Oregon's health care system.

On November 30, 2016, following OHPB's initial work to meet this request, Governor Brown sent OHPB a letter recognizing the work and formally requested policy recommendations to further advance health system transformation. The OHPB recognizes that as Oregon is nearing the end of the first five-year contracting period between the state and CCOs this is a logical moment to do this work and reflect on what Oregon has accomplished so far, what we want to accomplish in the coming five years, and how CCOs can continue to lead our transformation process.

To achieve the task the OHPB conducted a qualitative and quantitative analysis. Between June and January the board heard presentations, reports and recommendations regarding CCO performance and related policy issues and demographics. Additionally, an OHPB sub-committee led by Chair Smith, Joe Robertson, MD, and Brenda Johnson, partnered with local community advisory councils and regional health equity councils to conduct six listening sessions across the state. An online survey was fielded so anyone could provide feedback. More information regarding the specific quantitative data reviewed by the OHPB and details on the listening sessions can be found in the attached 2016 OHPB CCO Listening Session Summary Report.

The intent of the listening sessions was to hear directly from consumers, advocates, primary care providers and other stakeholders about the current state of CCOs and health system transformation and to identify additional hopes and expectations for our system as we move forward. We heard from roughly 600 individuals and organizations in person in diverse communities and through email, written letters and testimony at regular meetings. We received valuable input from CCO staff and leadership as well as non-profits and various other stakeholders. We heard about what has worked well and what hasn't and we reviewed data related to CCO performance and system performance. At the conclusion of the listening sessions critical themes we report include:

1. CCO coordination: CCO community coordination to address the social determinants of health has begun but must be accelerated and strengthened to reflect that health is largely determined by where people live, work, learn and play; focused improvement must extend beyond medical care.
2. CCO integration: The integration of physical, behavioral and oral health care services has improved but must be accelerated to realize the vision of an integrated delivery system.
3. Health equity: Health care delivery system disparities persist; strategies that address cultural competency, social stigmas, and equitable access must be given high priority.
4. Value-based payment: Continuing Oregon's progress with payment reform is critical for financial sustainability and improved health outcomes.
5. CCO governance and structure: CCOs have implemented community feedback mechanisms but the community's voice should be strengthened. Governance structures must reflect local community and public needs and be transparent and accountable; CCOs must invest savings in needed community services.
6. These themes shaped the organizing of our recommendations, which are intended to move us forward and realize the vision that was clearly stated and affirmed by the OHPB in our [2012 CCO Implementation Plan](#). Building from that plan, our recommendations fall into four policy areas and directly address:

CCO governance, transparency and accountability

- ✓ CCO priorities
- ✓ Fiscal transparency
- ✓ Accountability
- ✓ Community collaboration and input
- ✓ Monitoring and oversight

Health equity and the social determinants of health

- ✓ Health equity accountability and transparency
- ✓ Social determinants of health
- ✓ Workforce diversity

Accelerated system integration

- ✓ Physical, oral and behavioral health integration
- ✓ Primary care

Sustainable costs

- ✓ High-cost drugs
- ✓ Pay for value

The recommendations are intended to inform the next phase of health system transformation as it pertains to the coordinated care model. They act as policy guidance to the Oregon Health Authority and as information for legislators as they prepare potential legislation. They serve as our response to the Governor's request for specific recommendations regarding health equity and the social determinants, integration of physical behavior and oral health, accountability and transparency, and community partnerships and engagement. Please find the OHPB Recommendations for the future of Coordinated Care attached for specific policy recommendation details.

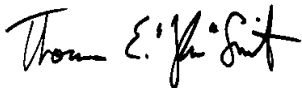
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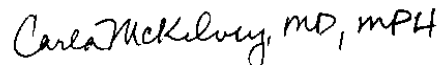
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Lastly, we would be remiss if we didn't address the significant and newly realized challenges our state is currently facing regarding health care. We face a significant budget shortfall this biennium and an ever evolving federal health policy landscape. The OHPB remains steadfast because Oregonians demand a better health care system; our vision remains focused on the foundation of human existence and quality of life – health. We believe the best way for Oregon to continue its health system transformation in light of current events is through continued improvement of the coordinated care model and enhanced collaboration and coordination with communities and providers across Oregon. We need only look inward to find the strength and reason to continue to lead; over the past five years we have dramatically expanded access to care: 95 percent of adults and 98 percent of children have coverage. We've lowered costs by bending the cost curve from 5.4 percent growth to 3.4 percent and realized improved health status¹. Oregon has proved that local communities and innovation drive successful health care transformation; we must pursue and promote continued progress that strives to improve health, improve care and lower costs for all. We look forward to working together to sustain improvements and focusing to build a better system for all Oregon.

Sincerely,



Zeke Smith,
Chair, Oregon Health Policy Board



Carla McKelvey, M.D.
Vice-Chair, Oregon Health Policy Board

CC: The Honorable Representative Mitch Greenlick
The Honorable Senator Laurie Monnes Anderson
The Honorable Representative Dan Rayfield
The Honorable Senator Elizabeth Steiner Hayward

Enc: OHPB Recommendations for the Future of Coordinated Care
2016 OHPB CCO Listening Session; Summary Report & Policy Option Areas

¹ as reported by a sampling of Oregon Health Plan members
http://www.oregon.gov/oha/Metrics/Documents/2015_Performance_Report.pdf#page=117



OHPB Recommendations for the Future of Coordinated Care

January 27, 2017

This matrix shows the Oregon Health Policy Board's recommendations for the next phase of Oregon's coordinated care organization model. Most of these policy recommendations should be addressed through CCO contracts and administrative rules. Unless otherwise noted, OHPB recommends that all of these changes be included in the next CCO contracting period, which begins Jan. 1, 2019. All recommendations may be subject to federal waiver approval, and changes in the State Plan.

	Policy Area Recommendation	Change Agent/ Change Path	Timeline to Implement	Triple Aim Values
Governance, Transparency, and Accountability				
1	Clarify CCO Top Priority: Require CCO contract to clearly state that the CCO's top priority and motivation is all three parts of Oregon's Triple Aim of better health, better care and lower costs.	OHA/ Admin Rule and CCO Contract	2019	Better Care, Better Health, Lower Costs
2	Improve CCO Fiscal Transparency: <ol style="list-style-type: none"> OHA collect and publish financial information related to CCO margins, medical and non-medical related costs, investments and payments made to partner organizations, in standardized formats, on a quarterly or annual basis. Set standards and expectations for reinvesting a reasonable percentage of CCO margins back into local communities toward deepening the impact on the triple aim. Develop a consistent and transparent approach to establishing reasonable reserves for each CCO. 	OHA/ Legislature Admin Rule and Statutory Change* *Reserves are in statute	2019	
3	Improve CCO Accountability: Develop more rigorous CCO contract criteria requirements which focus on: <ol style="list-style-type: none"> Addressing the social determinants of health; 	OHA/ Admin Rule and CCO Contract	2019	Better Care, Better Health, Lower Costs

	<p>2. Enhancing community collaboration and;</p> <p>3. Ensuring access to primary care, behavioral health and oral health.</p>			
4	<p>Clarify OHA Monitoring and Oversight Function: Further develop management and accountability system to ensure CCOs exhibit core functions as articulated in contract, rule and statute through standardized and least burdensome reporting. Partner with and provide support to CCOs as federal landscape evolves to ensure federal opportunities are captured as they are planned and implemented and CCOs have access to technical assistance as needed.</p>	<p>OHA/ Legislature</p> <p>Current Rule, Legislation and Statute</p>	2019	Better Care, Better Health, Lower Costs
5	<p>Enhance Community Access and Input to CCOs: Require each CCO to hold at least one public CCO governing board meeting annually in collaboration with their local community advisory council (CAC). Require one statewide annual CAC learning collaborative for all CAC members sponsored by CCOs so best practices regarding community collaboration, community input and improved local outcomes can be developed and shared. Require public transparency about who is on governing board and CAC via a standardized CCO report submitted to OHA annually. Require that at least one CAC member who is an Oregon Health Plan member or parent/guardian of a member, as identified by the CAC, serve on the CCO governing board. Require CAC contact information be clearly and publicly available to all community members.</p> <p>OHA conducts an analysis of CCO and OHA complaints and grievances procedures and makes recommendations in collaboration with stakeholders to improve those procedures.</p>	<p>Legislature/ Legislation and Statute</p> <p>OHA/ OHA</p>	2019	Better Care, Better Health
Health Equity and Social Determinants of Health				
6	<p>Strengthen Health Equity Accountability and Transparency: Focus on improved data collection; OHA transparency of</p>	OHA	2019	Better Care, Better Health

	<p>data; and member experience, measurement, reporting and outcomes for people of color, children and specific populations.</p> <p>Establish a Health Equity Subcommittee which reports to the OHPB and is charged with accelerating the development of policy related to health equity and ensuring health equity is considered in all policy.</p>	<p>Admin Rule, OHA/other</p> <p>OHPB</p>	<p>2017</p>	
7	<p>Focus on the Social Determinants of Health: Charge CCOs to collaborate with OHA's Office of Equity and Inclusion to ensure the social determinants of health including housing, education, criminal justice, employment opportunities, neighborhood environment and transportation, are addressed through community partnerships, collaborative community health assessments, community health improvement plans and transformation plans. CCOs work across jurisdictions with community partners to identify and target opportunities for improvement related to the social determinants of health.</p>	<p>OHA/</p> <p>CCO Contract, Admin. Rule*</p> <p>*Possible Legislation</p>	<p>2019</p>	<p>Better Care, Better Health, Lower Costs</p>
8	<p>Bolster Workforce Diversity: Use state incentive pool and strategies as identified by healthcare workforce committee to improve workforce training, diversity, and retention, specifically within underserved and rural communities. Identify and remove barriers related to payment, system structure and qualifications for use of traditional health worker services within community-based care through CCO contract or administrative rule.</p>	<p>CCO Contract and Healthcare Workforce Committee</p> <p>Admin. Rule*</p> <p>*Possible Legislation & may require federal approval</p>	<p>2019</p>	<p>Better Care</p>
Accelerated System Integration				
9	<p>Mandate CCO Oral and Behavioral Health (BH) Integration: Ensure CCOs have oral health contract flexibility, strengthen CCO contract regarding oral health integration mandate, and ensure oral health is included in CCO transformation plans. Ensure oral health providers have protections equal to</p>	<p>OHA and Legislature/</p> <p>Admin rule, CCO Contract*</p> <p>*Possible Legislation</p>	<p>2019</p>	<p>Better Care, Better Health, Lower Costs</p>

	<p>other providers in CCO and DCO subcontracts.</p> <p>Ensure BH delivery system contains “no wrong door” and strengthen CCO contract criteria to require seamless, consumer-facing integration of BH.</p> <p>Identify performance metrics consistent with the Oregon Performance Plan reflected in the three-year agreement with USDOJ.</p> <p>Charge and Metrics and Scoring Subcommittee to identify additional ways to incentivize CCOs to improve oral health, oral health integration, behavioral health and behavioral health integration.</p>	<p>OHA</p> <p>OHA</p>	<p>2017</p> <p>2019</p>	
10	<p>Increase Primary Care Spending and Accelerate Payment Reform: Align primary care payment practices with federal Comprehensive Primary Care Plus as per recommendation from SB 231 Primary Care Payment Reform Collaborative and require transparency regarding primary care spending, utilization and primary care value based payments.</p>	<p>OHA</p> <p>CCO Contract and Admin. Rule*</p> <p>*Consider statutory change to ensure clarity and compliance</p> <p>=</p>	2019	Lower Costs, Better Care, Better Health
Sustainable Costs				
11	<p>Reduce High-Cost Prescription “Budget Busting” Drug Prices: Contract for or conduct a comprehensive study and make recommendations to the Legislature regarding implementation and feasibility plans for:</p> <ol style="list-style-type: none"> 1. Increasing price transparency to improve public visibility and accountability; 2. Creating a public utility model to oversee in-state drug prices; 3. The creation of a single common and standardized Preferred Drug List (PDL) across CCOs and Medicaid FFS; 	<p>Legislature/ OHA/ Statute/ Admin. Rule*</p> <p>*Some may require federal approval</p>	2019	Lower Costs

	<p>4. Bulk purchase and distribution of high-priced, broadly indicated drugs that protect public health;</p> <p>5. Explore state ability to operate as pharmacy benefit manager to broaden purchasing and negotiating power and;</p> <p>6. Increased coordination with Washington state through the NW Prescription Drug Purchasing Consortium to increase Oregon Prescription Drug Plan (OPDP) purchasing power;</p> <p>7. Education for patients and providers regarding misleading marketing of prescription drugs.</p>			
12	<p>Increase use of Value Based Payment (VBP) :</p> <p>Institute expectations for the use of VBPs for subcontractors and providers related to behavioral and oral health.</p> <p>Collaborate with and help CCOs expand VBP arrangements with hospitals and specialty providers and ensure incentives for quality and efficiency.</p> <p>Create clear requirements and definitions for VBP; ensure that incentives reach treating providers.</p> <p>Require a percentage of CCO spending be value based and reported; set targets for VBP adoption and review outcomes and operationalization.</p>	<p>OHA/ CCO Contract, Admin. Rule*</p> <p>*Consider statutory change for clarity and compliance</p>	2019	Lower Costs, Better Care

December 2016

>> 2016 OHPB CCO Listening Session

Summary Report & Policy Option Areas

Oregon
Health
Authority
HEALTH POLICY & ANALYTICS

The Oregon Health Policy Board is charged with policy oversight of Oregon's Health system. The Board conducted targeted listening sessions in the fall of 2016 to revisit the state's vision for health system transformation and consider recommendations to improve coordinated care in Oregon's coordinated care organizations. To inform transformation progress and potential recommendations, the Board sought out community input around targeted policy areas from primary care providers, Oregon Health Plan members, health advocates and other stakeholders. Qualitative data from the listening sessions reviewed in this report demonstrates meaningful progress transforming Oregon's delivery system to meet the triple aim: Coordinated care organizations are improving health, delivering better care and bending the cost curve. That said, communities indicate the urgent need to build on and accelerate progress. Health should be better coordinated with the community to meet non-medical social determinants of health and confront health disparities. Coordinated care organizations should continue to strive to be more transparent and community voices must be heard to ensure community centered health. Integration of behavioral, physical and oral health care can be further improved to realize the vision of an integrated and coordinated system.

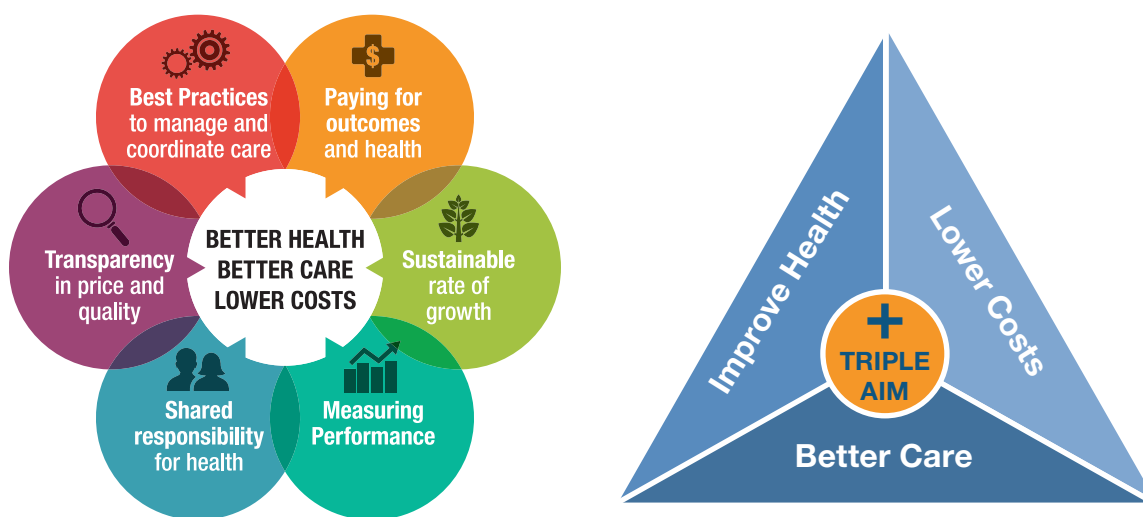
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Executive summary

This report contains information regarding the Oregon Health Policy Board's 2016 CCO Listening Session process, thematic outcomes and draft policy option areas regarding the future of Oregon's Coordinated Care Model.

Oregon's Coordinated Care Organizations were statutorily designed in 2011 through House Bill 3650 and launched in 2012 through Senate Bill 1580 after receiving approval through the Centers for Medicare and Medicaid Services with an updated waiver. Since their launch at that time 16 CCOs, the state and stakeholders have worked tirelessly to transform Oregon's health delivery system to better meet Oregon's triple aim of better care, better health and lower costs through the coordinated care model.



As the state nears the end of the first five year period with CCOs delivering care to over 1.1 million Oregonians, the Oregon Health Policy Board (the Board, OHPB) has been asked to review the vision for coordinated care and make recommendations to build on the promise and progress achieved by health system transformation and Coordinated Care Organizations thus far.

To meet this charge the Board reviewed quantitative system data at several Board meetings from July through December and appointed a sub-committee made up of Chair Zeke Smith, Chief Impact Officer of United Way Columbia Willamette, Dr. Joe Robertson, President Oregon Health & Science University, and Brenda Johnson, CEO of La Clinica, to tour the state from September to October seeking

qualitative input from all stakeholders including health care advocates, Oregon Health Plan members and primary care providers. In addition to the six listening sessions the Board fielded an online survey consistent with the questions asked at listening sessions. The survey was posted online for more than 45 days. The online survey was available in Spanish and English and was distributed through electronic newsletters, social media and via community outreach.

The questions asked by the Board are a synthesis of legislative direction, Board input, stakeholder feedback and OHA analysis. Criteria for choosing questions were based on Oregon's identified levers and drivers for health system transformation as articulated by Oregon's 1115 Waiver, State Innovation Model grant¹ and Coordinated Care Model Alignment Workgroup². Questions chosen were prioritized and the most impactful and potentially actionable were chosen.

Themes heard during the listening session were wide ranging. The majority of responses fall into the five broad policy areas targeted by the Board's questions regarding, coordination to meet community needs and better deliver services to address the social determinants of health, system integration of behavioral, physical and oral health, addressing health inequity, payment reform for value-based purchasing and flexible services and CCO governance and structure.

The Board is working to update its Action Plan for Health by the spring of 2017 to encompass a comprehensive update to health system improvement strategies, including opportunities and recommendations identified and developed for this report. Potential Action Plan foundational strategies and actions are used to align themes heard during the listening session. see Table 1.

¹ See <https://www.oregon.gov/oha/OHPR/Pages/sim/index.aspx> for more info regarding Oregon's SIM grant.

² See <http://www.oregon.gov/oha/OHPR/Pages/2014-Coordinated-Care-Model-Alignment-Work-Group.aspx> for more information regarding this workgroup.

³ The Department of Consumer & Business Affairs and the Market Place Advisory Committee administer and guide policy regarding insurance access, OHA/DHS implement Medicaid policy.

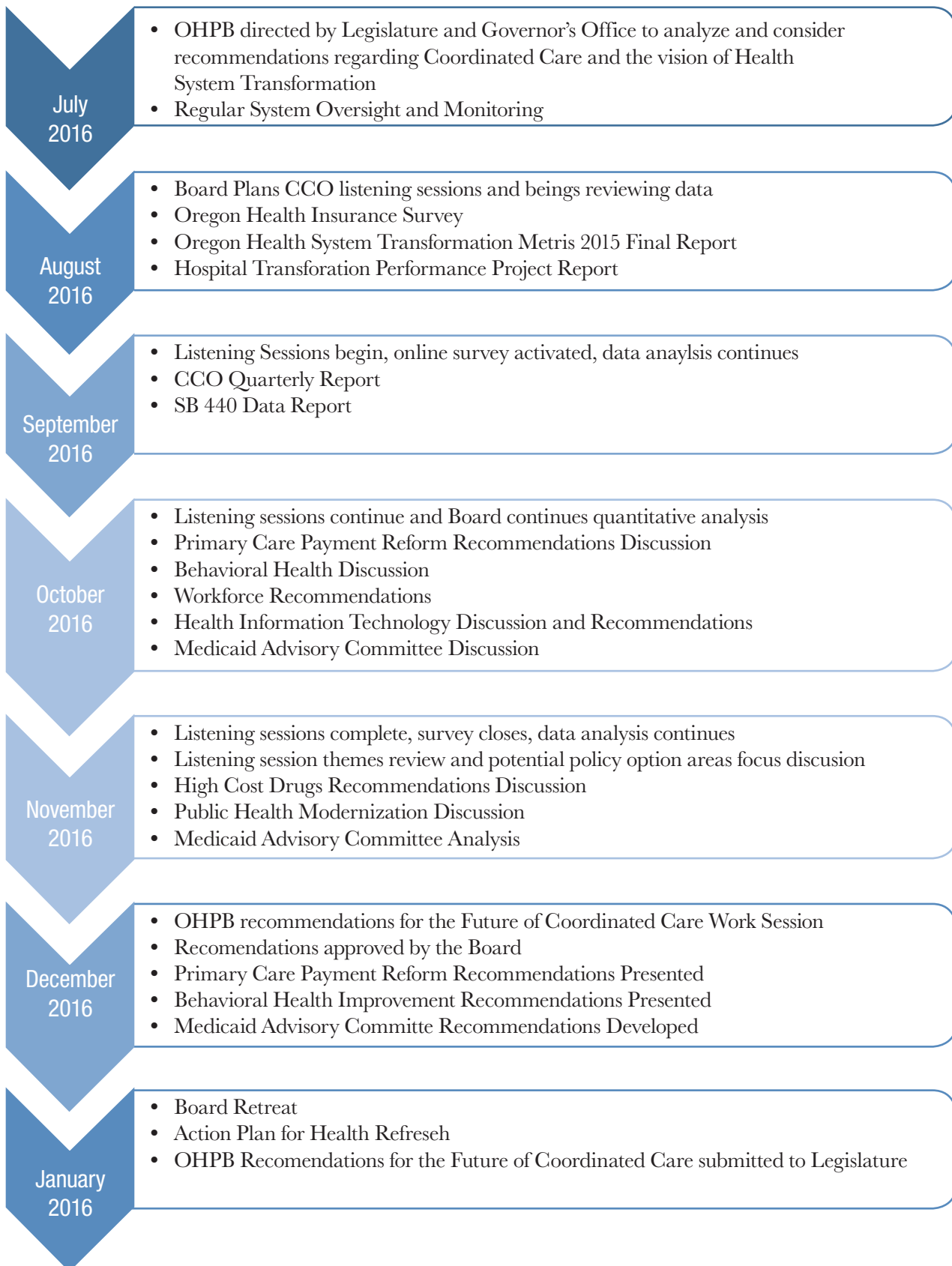
Table 1: OHPB CCO Listening session themes to action plan matrix

CCO Listening Session policy area	Action plan for health 2017 DRAFT foundational strategies							
	Change how care is paid for	Shift focus upstream to address the social determinants of health	Improve health equity	Ensure access to health insurance ³	Reduce barriers to care	Set standards for safe & effective care	Involve everyone in improvements	Measure progress
CCO Coordination	✓	✓	✓		✓	✓	✓	✓
CCO Integration	✓				✓	✓	✓	✓
Health equity	✓	✓	✓	✓	✓	✓	✓	✓
Value based payment	✓	✓	✓				✓	✓
CCO governance & structure	✓					✓	✓	

Thematic feedback is formed into the five broad DRAFT statements below based on analysis of listening session notes and survey responses.

1. **CCO coordination:** CCO community coordination to address the social determinants of health has begun but must be accelerated and strengthened to link Oregonians with the right kind of care at the right place at the right time.
2. **CCO integration:** The integration of physical, behavioral and oral healthcare services has improved but should be accelerated to realize the vision of an integrated delivery system.
3. **Health equity:** Health care delivery system disparities persist; strategies that address cultural competency, social stigmas, and equitable access should continue to be prioritized.
4. **Value-based payment:** Payment reform is in progress but needs more clarity, coordination and technical assistance to achieve critical mass.
5. **CCO governance & structure:** CCO’s have implemented community feedback mechanisms but the community’s voice should be strengthened. Governance structures should reflect local community and public needs and be transparent and accountable; CCOs should invest savings in community needed services.

OHPB coordinated care assessment timeline



Listening session themes

Feedback from listening sessions was collected at small group discussion tables by OHA staff and combined with feedback given through the Board's online survey. The survey was available in Spanish and any content or publication that was part of the listening session was available in another format or language as requested. Spanish translators and American Sign Language translators were on hand for each listening session. Criteria for choosing questions were based on Oregon's identified levers and drivers for health system transformation as articulated by Oregon's waiver, State Innovation Model grant and Coordinated Care Model Alignment Workgroup. Questions chosen were prioritized and the most impactful and potentially actionable were chosen.

1. Thinking about your local Coordinated Care Organization (CCO), what health care services are working for you, your family and your community? What could your CCO do to improve the health and well-being of families and the community? For example, are there specific services outside of a typical health plan benefit or resources that your CCO is providing or could help provide that would make a difference? Is health care connecting you with community resources to help with employment, housing, education, finances, and access to healthy foods and other essentials?

Sustain and Accelerate Community Coordination to Address the Social Determinates of Health

"Housing is cornerstone to health. Putting Community Health Workers in housing (especially those trained in trauma informed care/peer support services) is critical."

"Systems don't talk to each other. Lots of Electronic Health Records- Especially between mental health, dental and programs health."

"For its part, OHA also needs to be more accountable to members and provide support when CCOs are not providing necessary support. OHA also needs to re-evaluate how CCOs are incentivized to improve coordination and care"

"organizations, particularly health-related, seem to be talking to each other more over the past 3-4 years. (hospitals, clinics, etc) There is a sense that the CCO has helped to break down silos"

"...needs more help with housing and resources for homeless persons"

"I love the small town feel"

"CCOs need to "get credit" for good deeds/savings, e.g. high school grad and recidivism."

“In my experience as a community member, I felt like in the rural area that I live in, I had to access care in another state that did accept OHP, but was not aware of the benefits. When i would call OHA, i would get different answers and opinions.”

“Affordable housing to provide stability, particularly for the mentally ill is critical. Coordination of ALL resources, creating a “one stop shop” is desperately needed.”

“And I feel like CCO and OHA are not listening to the majority of complaints, especially around the patient-centered goal.”

“Good liaison with local hospital/Care Management on behalf of patients. Willing to pay for local Homeless Medical Respite Program which has been very helpful. There could be more flexibility for non-standard costs/benefits that would benefit all”

“We need to move away from medical model. I would like to see bio/psycho/social model integrated. I’m frustrated by the lack of knowledge about ACEs.”

“Why aren’t ccos able to process an address change?? We were on hold for 50 minutes with the OHA and then told they couldn’t process the name change because he was ‘in the old system’ and she could not access.”

“Change causes delivery system resets”

2. When reflecting on care received from a CCO, do dental care and mental health care feel connected with primary care? If they feel connected, please tell us why. If they don’t feel connected, why is that the case? For example, do primary care providers ask about overall health, including oral and behavioral health?

Integration of Physical, Behavioral and Oral Healthcare Services has Improved but More Work is Needed to Realize the Vision

“CCOs are not sufficiently connected with mental health services – there is no process to provide referrals for behavioral health treatment and there is limited colocation of services.”

“Neither dental nor mental health aren’t connected. Not even on the board of our CCO. Cannot have a CCO who doesn’t have those players at the table.”

“Still silos”

“OHP population is not connected – the docs punt client from CCO to local providers.”

“...some integration of mental health and physical health, but no evidence of dental integration.”

“Confusion on the part of members about dental benefits under their OHP”

“Primary care providers are asking about mental health but the referral process for the local mental health is a barrier to receiving services.”

“Yes my Primary Care Physician’s Medical Assistant asks about my oral and mental health. They even connected me to the Dental Clinic for dental cleanings.”

“I cannot answer for dental or BH in regards to how they feel. As a PCP, I am connected to the resources to ensure our patients get the care they need. As a PCP, we screen for BH as part of our check in process...built into the work flow.”

“Behavioral health is integrated with physical health at the pain clinic– members accessing services like yoga - into idea of alternative medicine.”

“Shortage of MH providers, in rural areas lucky if you get to see a psychiatrist in 1 years’ time. this is dangerous. Since members are using meds for that entire time without having the time to check in.”

“Member expressed a huge disconnect between her primary care not asking her about MH or dental.”

“Leave flexibility to meet outcomes, don’t define process steps”

3. For Oregon Health Plan Members and Advocates: Do you feel your needs are understood by others? Do you believe culturally appropriate services are available when needed? (This may include language interpreter and translation services, culturally competent clinical medical staff, access to a Traditional Health Worker, etc.). What barriers, if any, prevent you from getting the health or health care services that you need? (This may include language barriers, physical access, cultural differences, lack of cultural understanding, stereotyping etc.).

**Health care
Delivery
System
Disparities
Persist;
Cultural
Competency,
Social
Stigmas, and
Equitable
Access
should be
Prioritized**

“...our mental health services are very hard to access for Latino parents and they provided my family with interpretation from a staff! Not a professional the information she translated was not accurate and I had to sit down with my family to explain the information properly. Primary care providers never talk to be about oral or behavioral health and often times I have to educate them.”

“Dental services for those restricted to wheelchairs not accessible. Just because you are not in a chair doesn’t mean you don’t have a disability.”

“More language interpretation is needed, shortage of medical interpreters for all interpretation needs including spoken and sign language.”

“There is a lack of culturally-specific mental health services, especially for Spanish speakers.”

“Why do people think that culturally appropriate is limited to the color of your skin or where you were born?” There is a culture of poverty, a culture of people with disabilities, and a culture of those who have experienced trauma.”

“There is mental health stigma issues in different cultures, especially in the Hispanic community.”

“I’m seeing lots of stereotyping/shaming/stigma of OHP members. Culture of poverty judgements – amazed at the judgements staff make about this population. Work needed here. Also stereotyping those in recovery”

“The health care interpreter certification process is challenging for working people to navigate/complete.”

“Sometimes even certified health care interpreters translate things verbatim/too literally, so information can be misinterpreted by providers and/or patients.”

“211 is only as good as the information that is entered into the system. Many folks still are not familiar with 211 – it is underused – need to promote and educate.”

“Limited pool of interpreters is a barrier. Need more bilingual interpreters. In small communities, everyone knows everyone and they may not be comfortable sharing their issues.”

“In the local public health department, it is hard to find culturally competent, multi-lingual workers and there is currently a lack of staff with interpretation skills. Additionally, there are less interpretation resources for community members who speak languages other than Spanish.”

4. For Primary Care Providers: What’s been your experience with your local CCO around payment for providing high-quality care to your patients (i.e., alternative payment methodologies (APMs) or value-based payments (VBPs))? What’s working and what’s not? How can your CCO help spread APMs and VBPs in a way that works for you?

Payment Reform is in Progress but Needs More Clarity, Coordination and Technical Assistance to Achieve Critical Mass

“Value based may work for the CCO but not providers and consumers Increases administrative level for everyone.”

“It has been horrific. Our CCO refuses to offer APM, or VBPs”

“Scale in small communities? Primary care standards are variant, conflicting, burdensome (e.g. 86 metrics for primary care clinics in rural) standardize/streamline metrics, metrics changes hit primary care. Primary care physicians are burning out.”

“Both APM and VBP are being utilized. I feel these incentives are working to an extent; however, our board seems controlled by specialists and we primary care are getting less incentives each year.”

“we participate successfully in an apm takes a long time to gather the data they want to validate our “touches””

“APMs do not work when the hospital remains a small part of the CCO. VBPs may work, but again numbers (the volume) remain small and one adverse event can destroy a provider’s quality number.”

“Alternative payment allows an increase in team based care team and creative appointment types. This is critical to changing how primary care is carried out.”

“Our experience at our small rural health clinic has been that our CCO, pays us far below our actual costs of providing service. Their payment model is driving us out of business. We have not had any help from them in understanding their payment systems. I am not aware that we are getting any APMs or VBPs.”

“There is confusion about what VBPs actually are and what strategies can be used to pay differently.”

“The difference in metrics across payers (e.g., Medicaid, Medicare, commercial) make it difficult to align payment strategies because there are so many reporting requirements. Reporting requirements across payers make it difficult for individual practices to pay differently since it places an increased administrative burden on the practice.”

“Coordination is not being paid for under APMs/VBPs especially for behavioral health services. The case rate that has been negotiated does not necessarily compare to FFS.”

5. Regarding CCO decision making -- do you know who's "at the table" to make decisions? Who should be? What kind of decision-making structure would best reflect community needs and priorities? Should CCO decision makers be locally-based and part of the community?

**CCO
Governance
& Structures
Should
Transparently
Reflect Local
Community
and Public
Needs**

“Need more transparency; need stronger definition for who should be at the table (OHP member or CAC member should be on the board); unclear about governance – really need a way to ensure they care. In a small community, if you complain you're labeled as a troublemaker.”

“Lawsuits between community partners and CCO, creating major issues.”

“When we've inquired about anything at our CCO, the response has been that its proprietary info and not available to the public. CCOs were designed to serve the public with public funds, then the public has the right to know. This is a PUBLIC concern, not a business concern.”

“Finger is at the state, how could we allow this to happen”

“What is the healthcare of the community is more important than looking at the structure”

“Decision making processes of CCOS needs to locally based rather than use other external plans developed from other communities which doesn't reflect the local reality”

“There is a need to have local flexibility instead of operating on one size fits all.”

“CAC's are great things to have with within CCO. It enable consumer's voice and some ability to work on projects in community.”

“Headstart is not represented. Children/families who could be identified when child is four or five suddenly burst on the scene at seven or eight.”

“Should have open board meetings, published so clients can attend”

“Chaos from OHA leadership changes was burdensome; need stable agency infrastructure”

“Stay focused on triple aim on all policy areas”

“I know CCO was sold at an obscene profit to its shareholders at a time when many still struggle to get quality primary care. Shameful.”

“CCO decision-making should be limited to local (county) stakeholders, including the people giving and receiving services. Private, out-of-state ownership is not compatible with fairly reflecting the needs and priorities of the local community.”

“If you are not part of one of their “wholly owned subsidiary companies” then you are not defined as being a major component of the health care system here. I would like the CCO model to be opened up, public, and allow for more community input. The money to fund this model (the Medicaid waiver) should demand that the model be public”

Policy Option Areas Identified

Potential draft focus areas regarding CCO coordination

Coordination Policy Issue Area
Coordinated Health Partnerships: Support and develop 1115 Waiver demonstration concept which creates a five-year pilot program that seeks to address the social determinates of health and funds homelessness prevention, care coordination, and supportive housing services to at-risk adults and families. This work is underway, an advisory committee is being formed.
Early Childhood: Consider strategies and policies which ensure better coordination and integration of resources devoted to early childhood health to address adverse childhood experiences and the social determinates of health.
Community Benefit: Consider defining and setting standards and procedures for hospital and CCO community benefit to align with health system transformation goals, improved community coordination and Coordinated Care Organization improvement plans.
Social Determinates of Health: Consider defining a targeted percentage of budget that must be invested in addressing those social determinates that have a proven and direct impact on the health of CCO members.
Community Health Improvement Plan: Consider mechanisms to include important community stakeholders in community health assessment and improvement plan development who may not currently be at the table and related accountability mechanisms. Consider emphasis on prevention and addressing the social determinates of health in these plans.
Public Health Modernization: Public Health Modernization will ensure basic public protections critical to the health of all in Oregon and future generations by working to address the social determinates of health including clean air, safe food and water, health promotion and prevention of diseases, and responding to new health threats. This work is underway, legislation is prepared for the 2017 session.
Member Experience: Consider improving member experience with Oregon's Eligibility system (ONE) in the next phase of system build-out. Identify opportunities to improve processes regarding correspondence, renewals, cancellations and timely communication.

Potential draft focus areas regarding CCO delivery system integration

Integration Policy Issue Area

Oral Health: Consider meaningful integration of oral health by allowing CCOs to procure oral health services outside of local Dental Care Organizations (DCOs). Consider dropping the requirement that CCOs must contract with all DCOs located in their geographic area, some areas have as many as 9 local DCOs. Consider strengthening CCO contract language regarding oral health integration so that it reflects a level of integration emphasis similar to that of behavioral health integration.

Behavioral Health: Consider recommendations from Oregon's Behavioral Health Collaborative being presented in December as well as enhanced opportunities which increase accountability and flexibility for communities to find solutions that work.

Primary Care: Consider primary care multipayer alignment and informing guidance for Patient Centered Primary Care Home standards regarding upstream investment and shared responsibility for prevention. Consider the development and oversight of a plan to reduce administrative burden for all providers, especially primary care providers.

Prescription Drugs: Consider tasking the Oregon Health Plan Pharmacy and Therapeutic Committee to study and recommend a process to standardize formularies and reduce administrative burden. Consider researching and pursuing a west coast drug purchasing consortium made up of different states to better unify and take advantage of purchasing power.

Potential draft focus areas regarding improved health equity

Health Equity Policy Issue Area

Policy Development: Consider developing an equity policy body charged with considering the social determinants of health and addressing health equity to advise OHPB which may develop an equity agenda to inform a refreshed action plan for health.

Diversity: Ensure communities with health disparities have a voice, consider mechanisms to ensure some proportion of Community Advisory Councils be made up of these voices based on local population race, ethnicity, age, disability and native language status.

Programs: Continue to develop strategies and mechanisms to spread traditional health worker model, including peer delivered services and health navigators.

Cultural Competency: Design and develop improved cultural competency strategies regarding improved translation services, disability access and metric(s) which may measure baseline and benchmark improvement in cultural competency.

Potential draft focus areas regarding Paying for Value

Paying for Value Policy Issue Area
CCO Value Based Payments: Consider alignment with other value based purchasing initiatives like Medicare's alternative payment methodology effort. Consider setting a minimum ratio of spend which must be through VBP.
Primary Care Payment Reform: Consider alignment with CMS' Comprehensive Primary Care Plus program and Primary Care Payment Reform Workgroup recommendations.
Local Governments: Consider developing procedures and technical assistance for pilots which incent and spread integrated budgets aimed at addressing the social determinates of health and further coordination to deliver care amongst risk baring entities already responsible for care, e.g. local public and mental health efforts.
Global Budgets: Continue to lead the nation in the development of a global budget methodology which supports flexibility, integration and flexible services.

Potential draft focus areas regarding CCO structure

CCO Structure & Governance Policy Issue Area
CCO Mission: Oregon's Triple Aim (better health, better care, lower costs) should be the top business priority of any entity delivering or responsible for delivering CCO services in Oregon.
CCO Governing Board & Community Voice: Consider mechanisms which increase community and Oregon Health Plan voice to help build on CCO community based governance. Consider meta-analysis and significant best-practices review.
CCO Investments: Consider mechanisms and strategies which ensure CCOs transparently and collaboratively re-invest in their local communities.
Accountability: Consider developing a more rigorous CCO contract accountability system including the establishment of a set of clear criteria defining the common elements of a CCO by which each CCO must adhere. Re-develop and clarify policies and procedures regarding complaints and grievances for community members regarding CCO and OHA delivered services.

Community Input: Consider mechanisms to ensure CCO decisions are aligned with community need such as the CACs ability to transparently review CCO decisions related to community health and provide a non-legally binding vote of community support or denial when appropriate.

Community Advisory Councils: Develop annual Community Advisory Learning Collaborative Summit to spread best practices; ensure each CCO CAC is represented and can participate in shared learning throughout the year.

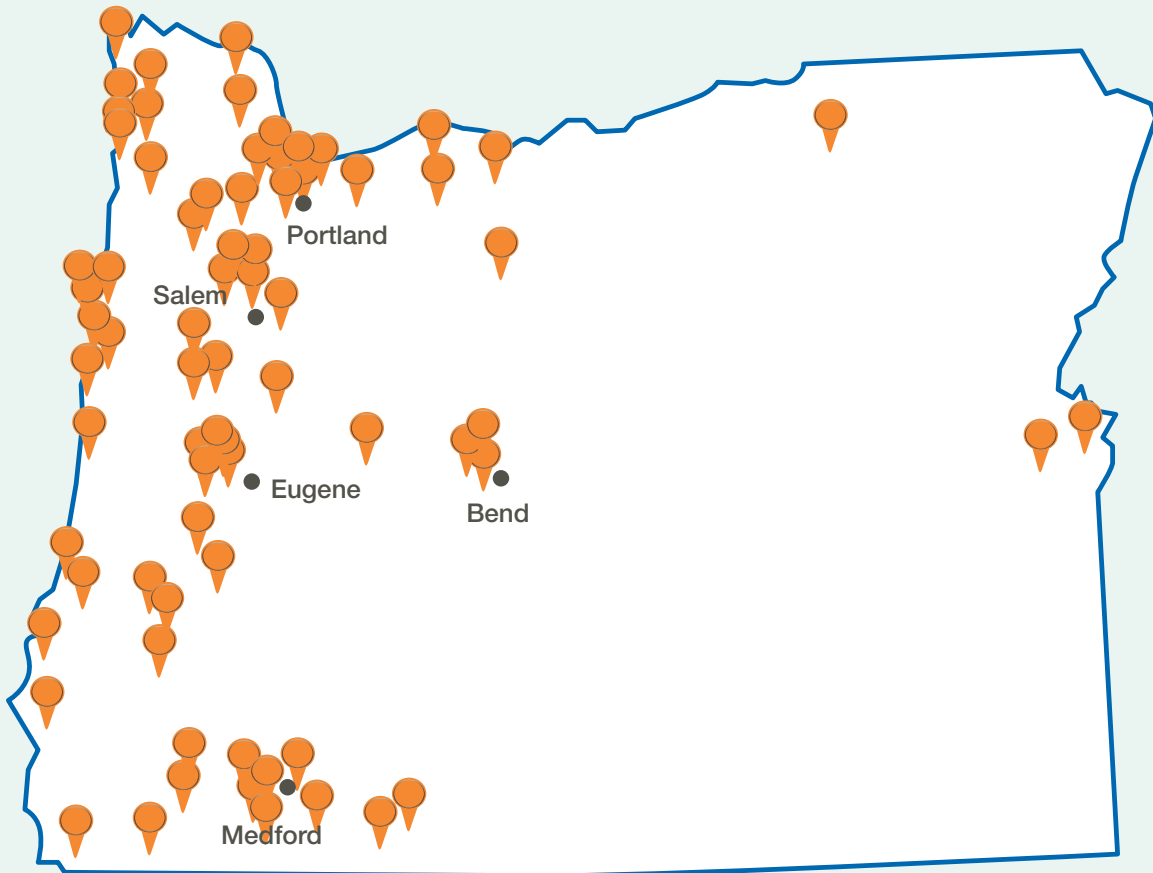
Transparency: Consider mechanisms which guarantee that at least once a year CCO Board meetings take place in the local community open to the public and all CAC meetings comply with public meetings laws. Consider requiring all CCOs to have an annual community meeting outlining core strategies and activities to deliver on Triple Aim.

Listening session details and demographics

The Board's CCO Listening Session Sub-Committee visited six locations across Oregon as shown in the table below.

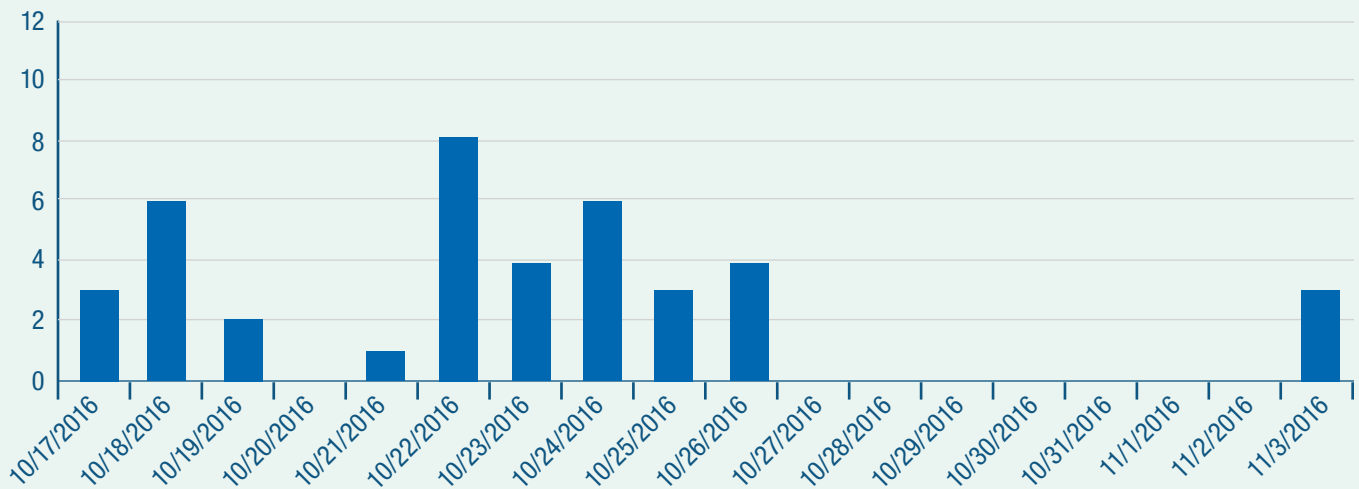
Date	Time	Region	Location	Attendance
9/1/2016	11:00-1:30	Bend	Deschutes National Forest Supervisor's Office Aspen Ponderosa Conference Room 63095 Deschutes Market Road Bend, OR 97701	50
9/9/2016	4:00-6:30	Tillamook	Port of Tillamook Bay Officers' Mess Hall 6825 Officers Row Tillamook	30
9/21/2016	5:30-8:00	Rogue Valley (Medford)	Inn at Commons Crater Lake and Rogue River Rooms 200 North Riverside Avenue Medford	80
9/26/2016	12:00-2:30	Eugene	Unitarian Universalist Church 1685 West 13th Avenue Eugene	120
10/7/2016	12:00-2:30	Pendleton - Hermiston	Eastern Oregon Trade and Event Center 1705 East Airport Road Hermiston	60
10/18/2016	4:30-7:00	Portland	Ambridge Event Center Ballroom 1333 NE MLK Boulevard Portland	120

OHPB CCO Listening Session survey geographic response map



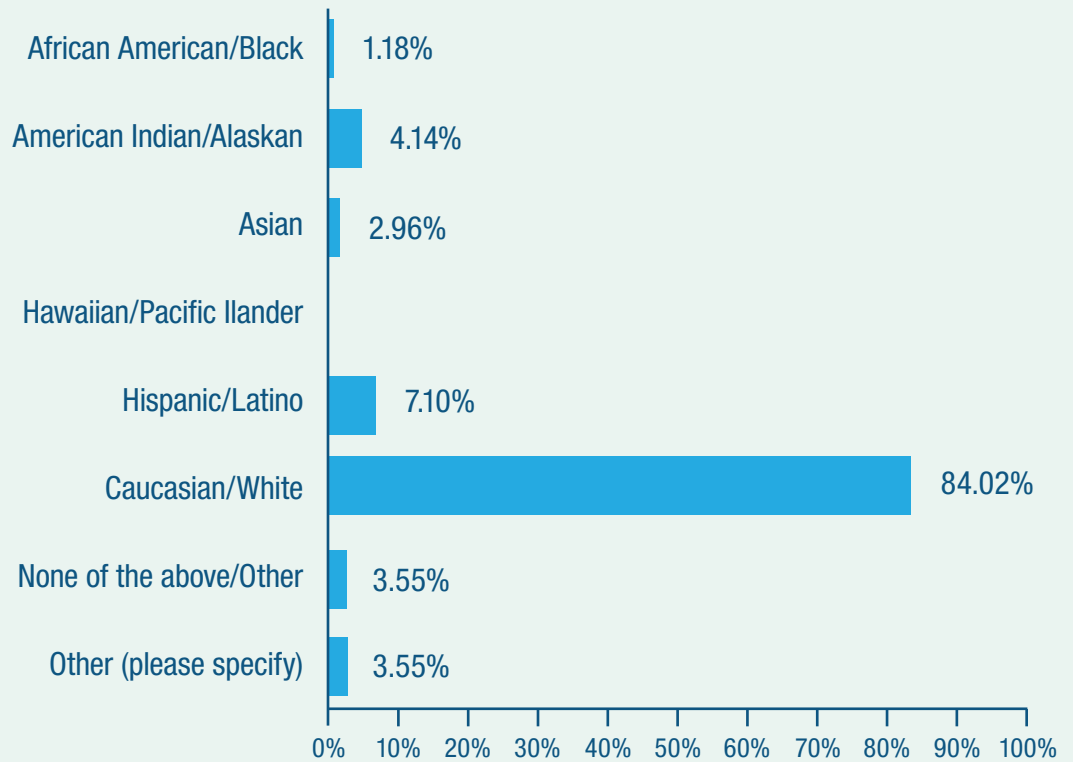
The Board received nearly 171 survey responses from September through November.

Survey response volume



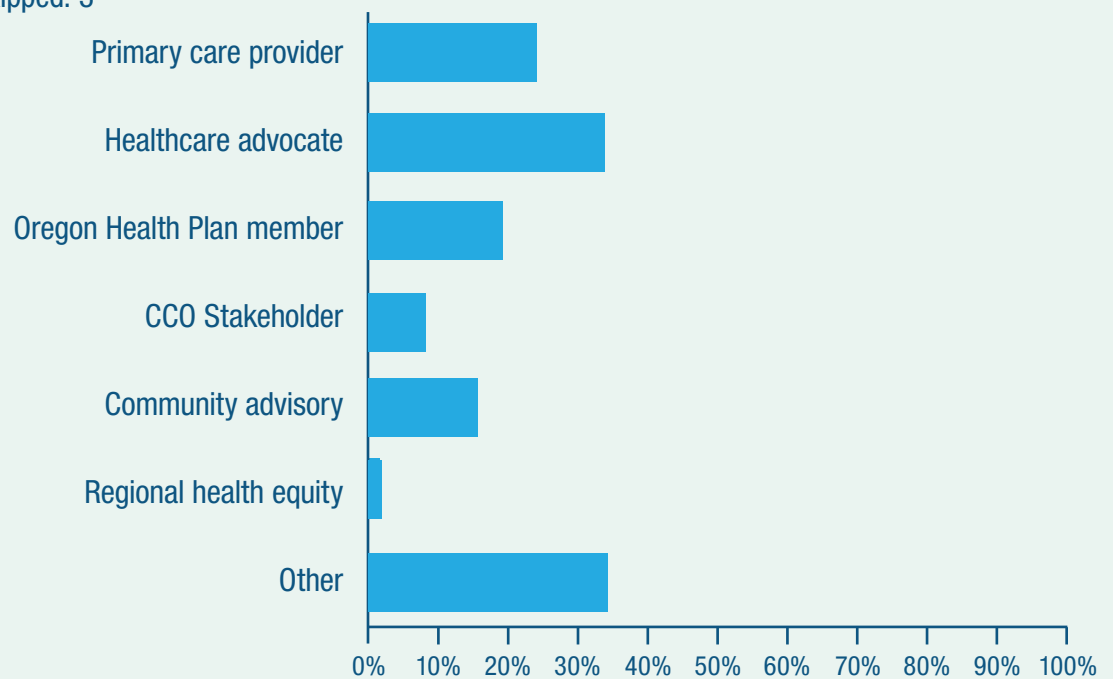
Survey ethnicity self-identification

Answered: 169 Skipped: 2



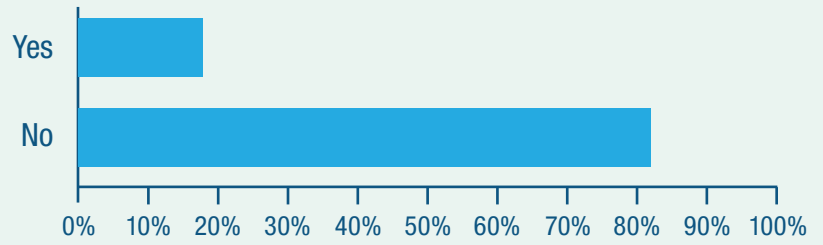
Survey stakeholder self-identification

Answered: 168 Skipped: 3

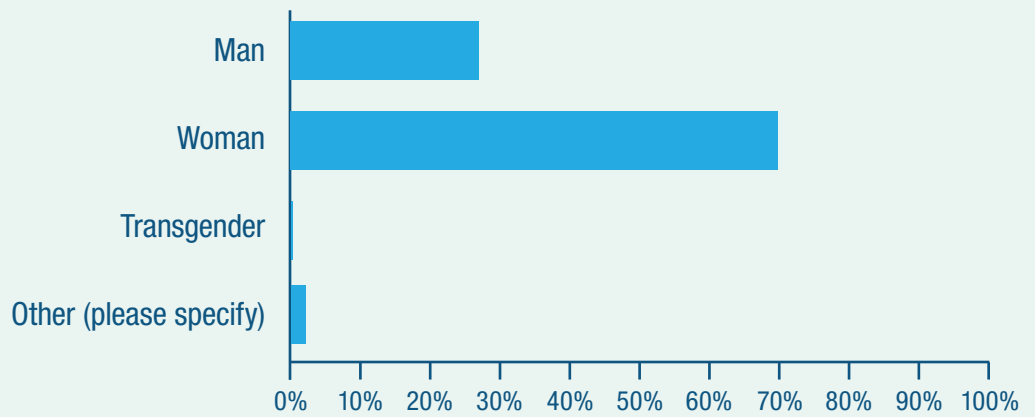


Survey disability self-identification

Answer: 168 Skipped: 3



Survey gender self-identification





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