OFFICE OF THE DIRECTOR

Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E20
Salem OR 97301
Voice: 503-947-2340
Fax: 503-947-2341
www.Oregon.Gov/OHA
www.health.oregon.gov

MEMORANDUM

TO: The Honorable Sen. Elizabeth Steiner Hayward, Senate Co-Chair
The Honorable Rep. Dan Rayfield, House Co-Chair
Subcommittee on Human Services

FROM: Janell Evans, Budget Director, Oregon Health Authority

DATE: February 17, 2017

SUBJECT: Responses to February 15 Public Hearing Questions

During OHA's presentation before your committee on Wednesday, February 15, committee members asked questions that required additional follow-up. Here are those questions and our responses:

Sen. Steiner Hayward (25 min): Which model are you using for that (in reference to home visits for moms/children)? Is it based on the frequency of visits?
Rep. Malstrom (26 min): Which program areas are we talking about?

> OHA Public Health works closely with the Early Learning Division and the home visiting programs they provide--Healthy Families Oregon and Relief Nurseries. They provide the leadership in convening stakeholders of all home visiting programs (including DHS) to create a coordinated home visiting system. Last biennium's SB 5504 budget note required all home visiting programs receiving state funds to coordinate and use a common entry/screening tool to streamline family entry into the system and ensure families are referred to programs that best fits their needs. It also requires outcome measures be defined for all programs to achieve to ensure program accountability and maximize benefits for families. Both of these pieces of work are nearly complete. OHA is in the final stages of

developing a data system that will support this cross-system coordination and accountability.

The expansion of nurse home visiting was actually from the child side (0-5 year) into the prenatal period--that was reversed in the testimony. In January 2017, OHA received approval from CMS to expand Target Case Management (TCM) SPA to include Nurse-Family Partnership, Expand Babies First! to include the prenatal period, and keep the existing child side of Babies First (0-5) and CaCoon (home visiting for children and youth with special health care needs, 0-21 years).

It does not include Maternity Case Management, which is a specific Oregon Medicaid program, of which home visiting is one means of implementing the program. This change will improve the continuity of care from pregnancy into early childhood, reduce the confusion of multiple funding and program requirements, allow home visitors to focus on what they do best (helping families, not necessarily billing) and be more seamless for families. Last biennium, the programs served over 15,000 women and children (including MCM); just over 10,000 of which were TCM supported. OHA anticipates with the expansion of Babies First to include the prenatal period that there will be a shifting of some portion of the visits from the child to the pregnant woman. However, research shows that this upstream intervention improves child health outcomes, requiring less need for support for the child.

An integrated and coordinated home visiting system is critical to assuring families have better physical, oral, social, emotional and mental health and are stable and attached, with our collective penultimate goal of Oregon's children entering kindergarten ready to learn.

Combined questions regarding the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey:
Sen. Winters (34 min): Can you break that out to regions – urban vs. rural (in reference to CAP survey)? At what point will we be able to say that the 20% we've targeted to reduce costs is healthier? **Rep. Alonso Leon** (39 min): What are the demographics of the CAP survey (minorities, gender, etc.)? **Rep. Rayfield** (42 min): KPM, is that an online survey or done through the mail?

Yes, mailing addresses can be used to break out the results by rural vs. urban. The CAHPS Health Plan survey includes a random sample of 900 eligible members per CCO in each age group (e.g., 900 adults 18 or older, 900 children 17 or younger). The sample is drawn for each CCO from members that to have been enrolled in Oregon Health Plan (OHP) for at least six months as of December 31.

Appropriate representation of minority populations is achieved through oversampling of minority race and ethnicity populations.
The CAHPS Health Plan survey is administered over a 10-week period between late February and early May using a mixed-mode five-wave protocol. This protocol consists of a pre-notification letter, an initial survey mailing and reminder postcard to all respondents, followed by a second survey mailing and reminder postcard to non-respondents. Phone follow-up is conducted for members who had not responded to the mailings. Respondents are surveyed in English and Spanish. The survey is done through the mail, not online.

Rep. Rayfield (39 min): Can you provide the committee with the link to Health Affairs article?

The Health Affairs article mentioned is not yet released. We will provide the committee with the link once it becomes available.

Here is the link to the article mentioned from The JAMA Network that provides a comparison of Oregon and Colorado's Medicaid accountable care organizations:

http://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2601417

In addition, here is the link to the Oregon's Health System Transformation CCO performance reports website:

http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx

Rep. Buehler (55 min): When will the demonstration clinics be up and running? Could you provide more information on that?

Please see the attached *CCBHC Demonstration Summary* for a description of the project and anticipated outcomes.

Sen. Winters (59 min): Do you have a map of where you plan to distribute resources across the state? How do you plan to deploy those resources (behavioral health resources) and integrate them into the community?

Please see the attached *CCBHC Locations* for the names and locations of CCBHC sites. Also attached is *Adult Mental Health Residential Locations and Area within 30 minute drive*. This is a sample of what the Behavioral Health Mapping Tool can provide.

Sen. Gelser (1 hr 1 min): What does OHA plan to do to invest in peer delivered services? There's a lot of discussion but the delivery is lacking for peer delivered services – is the Health Authority aware that advocates and consumers are feeling left out, that there's a problem in the relationship for peer delivered services? Can you come back with 3 specific actions with timelines for how that (feelings that action isn't being taken to provide peer delivered services) will be resolved?

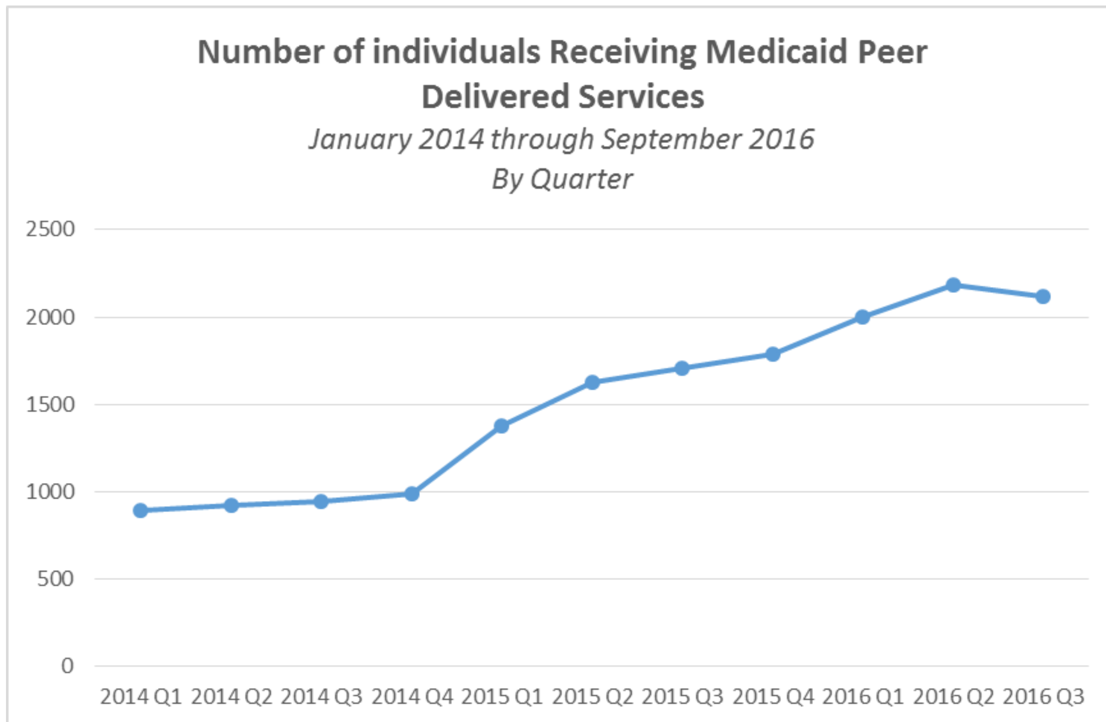
Behavioral Health Peer Delivered Services

The Oregon Health Authority embraces the value of peer delivered services (PDS) in the provision of behavioral health services. Some of the actions that OHA has taken in recent years to support PDS include some of the following:

- The establishment of the Office of Consumer Activities the in August 2014.
- Required and funded peer specialist in RFP for supported housing in 2013 and 2015.
- Recently updated Oregon Administrative Rules to require the availability of peer delivered services available.
- In 2016 OHA awarded 3 grants to develop Substance Use Disorder Facilitating Centers that focus on the expansion of peer delivered services for individuals in recovery.
- In October 2015 OHA funded 4 Emergency Department pilot projects to assist in the diversion of youth from hospitalization. The focus of these projects is to use peers to support the child and family. That project is being expanded to four other programs in 2017.

In addition to the above OHA activities, CCOs and CMHPs have projects and plans that expand PDS.

The following graph shows the progress that has been made in the expansion of PDS. It should be noted that this is Medicaid claims data and does not capture all of the PDS that are being delivered. For example, most of the PDSs provided in the activities noted above would not be captured in this data.



OHA continues to work to expand access to PDS. OHA will be evaluating contracts to strengthen language to promote access to PDS. The following are three activities that will support the expansion.

1. Expand PDS services provide by CCOs.
    a. Deliver training to each CCO on the efficacy of PDS – 7/31/17

2. Expand PDS services provided by Community Mental Health Programs (CMHP)
    a. Deliver training to CMHP directors on the efficacy 6/30/17
    b. Advocate to maintain existing funding for PDS in CMHP contracts within the constraints of current budget realities – 7/1/17

3. Consolidate activities of multiple groups/committees to focus efforts to expand PDS. Currently there are at least 3 different groups working on PDS. One group is within the Oregon Consumer Advisory Council and another is within the Addictions and Mental Health Advisory Council. OHA needs to build on the enthusiasm and energy of these group to achieve develop a focused plan to expand access to PDS. The tasks for the consolidation of these efforts include the consideration and prioritization of the recommendations that came from the Peer and Family Subcommittee of the Certified Community Behavioral Health Clinics project.
    a. The coordination of these groups will be achieved by 4/15/17.
    b. This coordination will result in a plan recommendation to OHA by 5/31/17.

The Oregon Performance Plan negotiated with the USDOJ requires a 20% increase in PDS the first year and another 20% increase in the second year. OHA will adopt similar metrics for all behavioral health populations.

In addition to the above activities OHA will continue to consider the inclusion of PDS in funded projects when appropriate and identify opportunities to strengthen language in contracts with CCOS and CMHPs for PDS. Opportunities for contract changes will be considered within current contract timelines.

2017-2019 CCBHC Demonstration

February 2017

PROJECT

The passage of the Protecting Access to Medicare Act (HR 4302) in March 2014, included provisions of the Excellence in Mental Health Act — an eight-state demonstration program and the single largest investment in community behavioral health in more than 50 years. Aiming to improve quality and access to behavioral health services through the creation of federal criteria for Certified Community Behavioral Health Clinics (CCBHCs) as entities to serve adults with serious mental illness, children with serious emotional disturbance, and those with long term and serious substance use disorders, as well as others with mental illness and substance use disorders. Twenty-five million dollars in planning grants was available to states to participate in a 1 year planning grant. Only states awarded a planning grant were eligible to apply for the demonstration program, a 2 year pilot program. Oregon applied for, and was awarded, the planning grant on October 19, 2015. Oregon applied for the demonstration program on October 28, 2016 and was selected as a demonstration state on December 21, 2016.

ANTICIPATED OUTCOMES

13 CCBHCs, representative of urban, rural, and frontier communities participate in the two-year demonstration

8 CCBHC Oregon Standards based on Behavioral Health Home Standards applied in year 1 of the demonstration

5 regional VA centers (Roseburg, White City, Portland, Boise, Walla Walla) engaged in care coordination with CCBHCs through 1 letter of agreement between VISN Region 20 and OHA

20 hours a week of onsite primary care provided by CCBHCs in year 2 of the demonstration.

13 organizations developing or enhancing trainings to address increased cultural competency of CCBHC staff

SCOPE

- **Monitoring & Compliance:** 13 participating CCBHCs will be held to federal and state standards over the course of the demonstration period
- **Data Collection & Analysis:** CCBHCs and OHA will be required to report on a total of 21 metrics, beginning in Q4 of 2018
- **Prospective Payment:** CCBHCs are eligible for organization-specific rates associated with demonstration services. Submission of a cost report is required in 2018

APPROACH

This project relies on twelve-months of work associated with the 2015-2016 CCBHC planning grant. The 2017-2019 Demonstration is scheduled to begin on April 1,2017 and is supported by OHA staff and resources to meet deliverables required by SAMHSA and CMS.

TRANSITION TO OPERATIONS

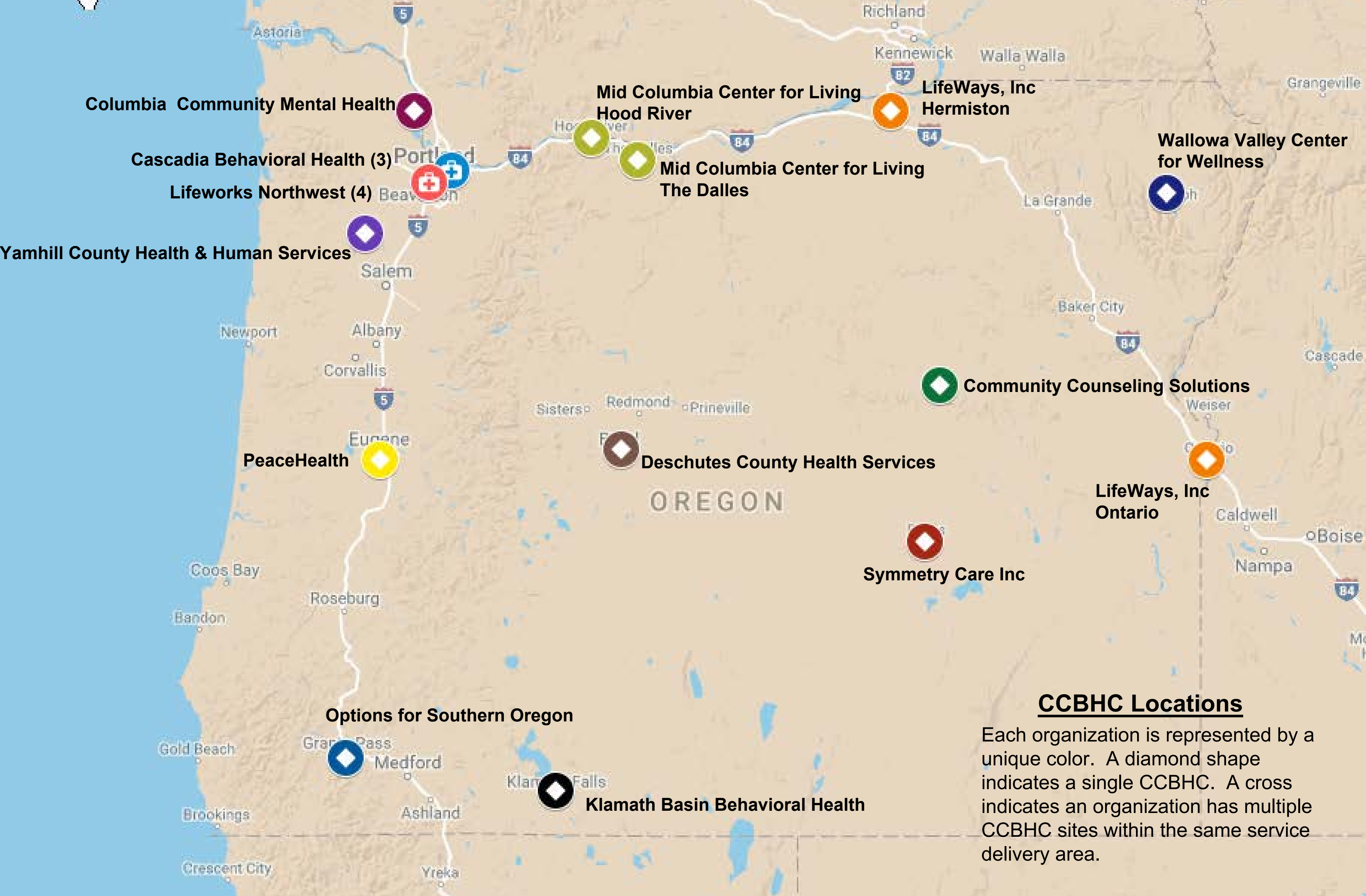
Successful planning to operations will be considered throughout the demonstration period. Currently, billing, data collection, and compliance work is being coordinated within OHA's existing systems

PROJECT STAFF

Project Leadership: Royce Bowlin, Mike Morris

Project Manager: Emily Watson

Project Partners: OHA Financial Services, OHA Actuarial Services, Optumas



CCBHC Locations

Each organization is represented by a unique color. A diamond shape indicates a single CCBHC. A cross indicates an organization has multiple CCBHC sites within the same service delivery area.

Adult Mental Health Residential Locations and Area within 30 Minute Drive