

Oregon Health Policy Board
DRAFT April 5, 2016
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

Item

Welcome and Call To Order and Roll

Present: Chair Zeke Smith called the Oregon Health Policy Board (OHPB) meeting to order. Board members present: Zeke Smith, Carla McKelvey, Karen Joplin, and Joe Robertson and Carlos Crespo, Felisa Hagins

Zeke announced that there are open seats on OHPB and solicited membership applications.

Reviewing the last meeting summary notes, Zeke read through the *Action Plan* that was discussed at the last meeting from the minutes as a reminder of the goals that this group is working towards. The minutes from last meeting March 1, 2016 were approved.

Director's Report, Lynne Saxton, OHA

Lynne Saxton updated the Board on the **Oregon Eligibility (ONE)** system, which is the new software that is being used to enroll Medicaid applicants since December 2015. As of March 17, 2016 more than 61,000 applications have been completed in ONE. With each month, the data quality and the major technology issues are being worked on. PMG and Deloitte Consulting are on board to assist with technological issues. CMS is focused on the success of our system to enroll over 1.1m applicants in Oregon, specifically for members to be able to enroll easily and make it accessible on many levels.

Lynne emphasized that the goal is to ensure that members get service across the continuum of the four stages of eligibility, redetermination, membership and closure. Dr. Chauhan has been instrumental in the ensuring that the membership services function are being addressed.

Redetermination is one of the four processes that is not yet available on the ONE system. Lynne will ask Dr. Chauhan to follow up with Karen Joplin and their CCO on enrolling of newly pregnant women. Each CCO is being treated separately with their specific issues. *Lynne would like to hear personally from anyone with questions so that it can be dealt with immediately.*

Portland Metals and Toxics report

Oregon Public Health produced a 2 page executive summary on the developments thus far. **Safer Air Oregon** website is being updated every day with the latest news and current developments. <http://saferair.oregon.gov/Pages/index.aspx>

OHA and DEQ are working intensely on monitoring and reporting on public health information out to a wide audience. A timeline for a permanent rulemaking to address the broader issue of health risk air toxic regulation consistent around the models in place in WA and CA is forthcoming. There will be intensive public engagement and an opportunity to address the gap in Oregon by examining the best practice framework that is required. A webinar and a town hall meeting is also being scheduled.

Concern was expressed about whether the air pollution issue in Portland was a one off incident or whether there are other incidents lurking around the state. Lynne emphasized that

monitoring standards across the whole state will be looked at. OHA will investigate standards across Oregon; this is a crucial opportunity to move forward in a substantive scientific way with support from the EPA and other agencies involved.

Tribes and native peoples across Oregon

Tribes have expressed concern that they are not getting access to CCOs. Lynne reported that the Federal government is fully funding FMAP for Native Americans which addresses access to specialty care. Karol Dixon, OHA's new Tribal Liaison, is working to compile a dataset that which will examine the challenges across the state for Native Americans. In addition, webinars and meetings are being planned through o identify barriers to cultural competent care. Solutions can then be identified.

The Open card issue for Native Americans is being examined. 75% of Native Americans live in urban communities and this adds to the complexity of identifying their care.

Lynne relayed that an independent analysis of culturally competent care is being conducted which will feed into the next metrics presentation or even sooner.

Leslie Clement added that the Director of OEI and Chris DeMars of the Transformation Center are also aware that three of their performance areas are around cultural competency. Leslie will follow up with them and put together a working panel to further review the issue.

Joe Robertson added that the original treaty with Native Americans was that there was a differentiation between primary and specialty care and it could be provided by a provider on a horse.

Public Health Advisory Board (PHAB) charter review

Dr. Robertson provided an introduction to the Public Health Advisory Board (PHAB). The PHAB was established by HB 3100, as part of a concerted effort to modernize public health. Since it was established in December 2015, they have met twice and intend to meet more often. They have made a concerted effort to modernize Public Health in Oregon. Traditionally, much of public health nationally and in Oregon was designed to be reactive, particularly to outbreaks. Public health modernization moves towards a new model in Oregon, focusing on population health. The greatest burden of illness is chronic disease. "Public health is not what you get when you go through the door for care, but tries to help you to *not* need to go through that door".

Carrie Brogoitti from La Grande, the Vice Chair of PHAB, briefed the charter and the highlights of the work plan for PHAB as outlined in the attachment. At their March 17, 2016 meeting, they discussed the public health modernization process and a report will be published in June 2016.

The Board recognizes the large amount of work that PHAB is undertaking and it would be good to have a timeline from PHAB on how this connects with other work the Board has to oversee, including the SB 440 & waiver timeline. Additionally the Board would like PHAB to be clearer about how OHPB and PHAB can engage and support each other proactively.

The Board would also like to include a vision statement and how public health connects with the goals of the State Health Improvement Plan (SHIP).

Another comment from the Board was specifically around objectives (i) and (j) on page 3 of the charter. The Board would like to add a friendly amendment to include the word “support” in both objectives on the right hand side.

With that amendment, the charter was approved.

Carlos requested the PHAB reach out to public health students to see how they can assist in this great opportunity of the modernization of public health in Oregon.

Health Systems Transformation Primary Care Spending in Oregon and Senate Bill 231 about Primary Care Payment

Leslie introduced this topic which has been before the Board before. The Board approved support for Primary Care in Oregon, specifically to address the sustainability and commitment across all payers. Senate Bill 231 was passed in 2015 with the aim of strengthening Oregon’s primary care infrastructure. The meeting materials includes a one page summary of SB231.

Senator Dr. Elizabeth Steiner-Hayward presented a report on *Primary Care Spending in Oregon, February 2016*. This report was sent to the Legislature to help policy makers and the public assess the resources allocated to primary care in Oregon and develop proposals for improving primary care. The report provided a detailed first snapshot of the percentage of medical spending allocated to primary care across multiple payers using information from 2014.

Senator Dr. Elizabeth Steiner-Hayward stated that the “fee-for-service” model is broken for paying for healthcare. It incentivizes the wrong kind of care, it dis-incentivizes the right kind of care and it is outdated and does not support achieving the triple aim.

Senator Dr. Elizabeth Steiner-Hayward would like the Board to push insurers for a commitment to develop and support alternative payment methodologies that support the work of the primary care and thus lower our overall health costs. The Senator asked the Board to work to unmask carrier identifying data in the Primary Care Spending Report.

Dr. Robertson voiced his disappointment at the All Payers All Claims database. It needs to be improved. He would like the Board to follow up on this issue.

Zeke Smith added that it would be helpful if the Board could help by bringing these ideas together for the 2017 legislation. Carlos added that we need to include the voices of the consumer to the table.

Lynne Saxton introduced Dr. Jim Rickards, the Chief Medical Office for OHA, who joined us in January 2016. They are also hiring a Behavioral Health Director in the new future.

Among his duties, Dr Rickards oversees the PCPCH. He gave his responses to the questions that the Board had given him. From his previous work as a Health Strategy Office in Yamhill county, he has had an opportunity to see how the CCO model works at a system level. In general, he sees that the CCOs spends the most on primary care and the model is working.

- How do you build your primary care network?

They build relationships and foster coordination and with the dollars and money given to the CCOs, they can allocate more payments for primary care. For instance in Yamhill, they gave a 6% higher reimbursement to primary care. They took the financial incentive dollars for meeting the 17 performance metrics and gave them to the primary care providers to reward them.

- How does OHA interpret this?

From a high level view, giving communities the CCO model platform where the communities and providers has the opportunity to spend more on primary care. One of the main 8 performance metrics was the development of the PCPCH within their network. This was a success.

They also have an opportunity to spread this model.

- Did the report align with what you think you would find?

From the CCO perspective, they had a capability and flexibility to spend more on primary care.

- Is 10% average spend right?

Looking at the successes the CCOs have had so far decreasing ED utilization, decreasing diabetic admissions, etc. he thinks that it is fair to say that the 10-13% range is the sweet spot and is producing results.

- Should we make anything of the range of spend?

Different CCOs have varying levels of, some had to shift their priorities, some had to spend more to get it up and running.

Dr. Robertson noted a potential issue regarding the percentage number as a comparator considering variation in payment based on different carriers. He noted the rising cost of formularies and voiced concern that a percentage number will not reflect the true cost. Dr. Rickards thinks that there is the potential to move in that direction focus on non-claims payments and develop models that pay for different aspects of the model.

Karen Joplin had a concern about PCPCH tiers. As the rules for the tiers process change for PCPCHs, what will be the effect on clinics in 2017? 85% of clinics are at Tier 3 currently. There will be a gradual evolution of the PCPCH standards however the verification process is rigorous and collaborative. Dr. Rickards thinks that there is a lot of opportunity to improve. Learning and sharing PCPCH standards is crucial.

Senate Bill 231 also required the OHA to develop a **Primary Care Transformation Initiative** to share best practices in technical assistance and methods of reimbursement that direct greater health care resources and investments towards supporting and facilitating health care innovation and care improvement in primary care.” Diana Bianco has been organizing this initiative and has been working with the Transformation Center on pulling together a large

group of payers, about 45 people, for this Multipayer Collaborative. The first meeting will be in mid-April. The goals of this group are to:

- Identify best practices that support primary care through technical assistance, methods of reimbursement and evaluation
- Work together to seek alignment and agreement around next steps to support sustainable integrated, team-based primary care and achieve the Triple Aim
- Provide support and opportunity for subgroups to identify and work on shared interests and activities to support primary care transformation

Questions from the Board on this:

- Do these goals match the original goals from the voluntary agreement that the Board set?

Diana responded that these goals came from legislation, and will ensure that she checks with the initial Multipayer agreement. Leslie and Lynne added that rather than re-invent the wheel, the goal is to ensure that there is the mechanism to fund primary care. As Lynne has toured the clinics she discovered that ROI for the clinics has not been captured and OHA can assist with providing cost-efficiencies and process engineering for the model. OHA can do the financial analysis also. This will be crucial to help with the goal of best practices and sustainability.

Zeke reminded the Board that Senate Bill is clear about the end game of this process, which is primary care transformation and reimbursement. Zeke would like this collaborative to be very visible about the end game so that the information and recommendations coming out of this collaborative will be specific. Diana will make sure that the language from SB 231 will be added to the charter of the group.

Diana also solicited the Board to give her their big picture view of what the Board would like to see to ensure that this collaborative is a success. What role would the board like to see this collaborative to play?

- Dr. McKelvy would suggest that the vocabulary is based on current vocabulary, not old language, specifically ICD10.
- Felisa hopes that in 3-6 months, a foundational agreement can be established by this Multipayer Collaborative that people are publicly committed to. Also can there be a measurement/process system for the payment systems to be in place?
- Karen would like to see a list of 45 stakeholders.
- Dr. Robertson would like to see a report of some kind of consensus of the degree of success from the provider community, e.g. what they can benefit from this collaborative.

- Carlos wants to see a wide range of payment methodologies and an analysis of what would function best.
- Zeke would like to see tension points and barriers from the providers. What does progress look like moving forward? It will be interesting to see this at a state and local level and also federal barriers, if any. How is the state supporting the intent? Zeke would like to take up Senator Dr. Elizabeth Steiner-Hayward's offer to provide her expertise to this collaborative and to the Board.

Diana solicited feedback and asked that comments be directly sent to her.

Oregon 1115 Waiver renewal update and discussion about housing opportunities

Bill Wright from CORE Providence gave an overview of the study that they completed in February 2016 – Intersection between Health in Housing Study. The report outlined recommendations and next steps to support Medicaid recipients. A copy of the report is included in the materials packet.

The 4 main findings from the study are:

- After people moved into affordable housing , there was a reduction in health care expenditures
- Utilization pattern shows a decrease in emergency department, and increase in primary care use
- Survey of sub-set of population shows that people were more likely to say that care was much better than what they were used to receive
- Looking at presence or absence of services (not whether people were aware of the services or not), conservatively it can be said that sites that had health reduced services in place had reduced expenditures.

Another round of research will be done with this initial research to expand on what has been done.

Amanda Saul, Senior Program Director from Enterprise Community Partners, also provided information regarding the study. They recommend Medicaid help pay for housing and supportive services. In Multnomah county alone, they are 40,000 units short of affordable housing needs for the community. State and federal resources to provide housing or rental assistance for people should be better aligned. Additionally, they recommended the state pursue waiver changes to allow the use of flexible benefits and incenting CCO to use those benefits towards housing and housing related services.

Kenny LaPoint, a housing integrator from the Housing and Community Services (OHC) gave an overview of the Oregon Housing and Health Care Integration Best Practices study. A copy of the report is included in the materials packet.

Kenny' major focus is to work across the state and consider how CCOs, housing and health can be better coordinated. OHA and OHC have been selected to participate in the Innovation

Accelerator Program (IAP), one of the 8 states selected to participate. The OHA and OHC will be working closely together on this program.

Questions from the Board:

- Felisa wanted to know what CCOs are currently contributing towards supportive services. She would like to see this by CCO.

Lori said that in terms of rental assistance for permanent house, Medicaid does not support this. Contributions vary across CCOs. Kenny emphasized that there was a misleading news report that said that States Medicaid dollars are used for housing.

Leslie added that OHA is doing an inventory of all transitional programs across the agency. There is also a request for the federal government to do more pilots.

- Dr. Robertson acknowledged that we are at a transformational moment comparing to where we were 4-5 years ago. We are moving in the right direction and it is clear we are not just about Medicaid policy, but social policy as it pertains to homelessness. What he has not heard in these discussions is around the prevention of homelessness and the incarcerated.
- Karen Joplin wanted to know if there opportunities for public input in the waiver process between now and June? Lori Coyner will present again at the OHPB May meeting. They are presenting at the Medicaid Advisory Committee meeting on April 6, 2016. There will be opportunities for public comment then. Leslie added that they are using all the current work group avenues in order to talk about the waiver.
- Karen also commented on CCO hesitance around housing revolves around the medical loss ratio and may affect them negatively. Lori said that flexible services are not counted in rate development. They are counted in admin, not medical services but conversations with CMS regarding this issue are ongoing.

Zeke asked the Board to affirm the policy direction as presented in regards to housing and the waiver. The Board affirmed the policy direction.

1115 Waiver public testimony

1. **John McConnell**, is a health economist from the Center for Health Systems Effectiveness, OHSU. They are conducting a variety of studies on Oregon's transformation and CCO. He wanted to briefly comment on the CCO success and the waiver. The metrics both in terms of spending and quality look good. Performance on the quality measures look good. Other measures show mixed results, incentivized measures do better than other measures. Some of the trends are matched in other populations. The emergency department use has come down more in 2014 than 2013, showing good evidence of a trend.

2. **BJ Cavnor** is the executive director of One in Four Chronic Health in Portland. He is spoke on behalf of the Oregon Hepatitis Treatment Access Initiative. This initiative is a group that navigates treatment for patients who have HIV/Hepatitis C. They have reviewed Dr. Rickards' letter to CMS regarding the issue and voiced strong disagreement. They are concerned that there isn't a guideline for treatment of people co-infected with Hepatitis and HIV especially when they have a separate funding source that could cover the cost of these patients. They do not want to endorse the renewal of the waiver without a plan in place for Medicaid patients with Hepatitis C.

At Carlos's request, BJ will get back to the Board on the % of people who have HIV who are also infected with Hepatitis C.

Public testimony – non waiver related

1. **Ken Meyers** is a retired hospital administrator and volunteer for Health Care for All Oregon. Their organization has been working for years for a publicly funded universal health care program for Oregon. They would like to coordinate planning efforts with OHA. HB 2828, a companion bill of HB 3260, passed in 2013 to establish a fund to study financing on health care with \$300,000. The RFP for this is being reviewed and scheduled to be awarded in mid-April and report will be presented to Legislature in November 2016.

HCO is planning a comprehensive report based on this study. They are requesting that OHPB make time on their agenda to explore how these efforts can be integrated.

Zeke reminded the Board that Felisa has been discussing staff a protocol on how to deal with the large volume of topics and presentations and suggest a way to make extra time for the Board for discussion.

With that, Zeke called the meeting to a close.

OHPB video and audio recording

To view the video, or listen to the audio link, of the OHPB meeting in its entirety click [here](#).

Adjourn

Next meeting:

May 3, 2016

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3303 SW Bond Ave, 3rd floor Rm. #4

8:30 a.m. to 12:00 p.m.