Conference Call Number: 1-888-808-6929
Public Participant Code: 915042#

Oregon Health Policy Board
AGENDA
June 5, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 2:00 p.m.

#	Time	Item	Presenter	Purpose
1	8:30	Welcome & Minutes Approval	Zeke Smith, Chair	Action
2	8:40	Public Testimony		
3	9:00	OHA Report: Reorganization	Jeremy Vandehey, OHA Director Health Policy & Analytics Division	Vote
4	9:15	CCO 2.0: Behavioral Health Policy Option Review Session	Mike Morris, OHA, Behavioral Health Program Administrator Jackie Fabrick, OHA, Behavioral Health Policy	Update & Discussion
5	10:10	Break		
6	10:20	CCO 2.0: SDOH and Health Equity Policy Option Review Session	Chris DeMars, OHA, Transformation Center Director Leann Johnson, OHA, Director Office of Equity & Inclusion Amanda Peden, OHA, Health Policy	Update & Discussion
7	11:15	Lunch Break: Working Lunch		
8	11:25	CCO 2.0: Cost Policy Option Review Session	Laura Robison, OHA, Chief Financial Officer Chelsea Guest, OHA, Actuarial Manager Tim Sweeney, OHA, Health Policy	Update & Discussion
9	12:20	CCO 2.0: VBP Policy Option Review Session	Chris DeMars, OHA, Transformation Center Director Lisa Krois, OHA, Transformation Analyst	Update & Discussion

			Zachary Goldman, OHA, Economic Policy Advisor	
10	1:10	CCO 2.0 Reflections Discussion	Chair Smith	Discussion
11	1:20	Health Plan Quality Metrics Committee: Measure Selection	Kristen Dillon, M.D., Director PacificSource Columbia Gorge CCO and HPQMC Chair Shaun Parkman, Evaluation Specialist, Oregon Public Health Division and HPQMC Vice-Chair	Discussion & Informational
12	2:00	Adjourn		

Next meeting:
July 10, 2018
OHSU Center for Health & Healing
3303 SW Bond Ave, 3rd floor Rm. #4
8:30 a.m. to 12:00 p.m.

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2018 OHPB CALENDAR

DRAFT

Updated 5/29/18

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
January 2, 2018	• OHPB Retreat • CCO 2.0 Development & Planning • Action Plan for Health Update	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Oregon Health Insurance Survey Fact Sheets -CCO Metrics Report	Health Care Workforce Assessment due to Leg. Assembly. Behavioral Health Collaborative progress report due to JCW&M
Feb 6, 2018	• 2018 Legislative Briefing	• Improve health equity • Increase access to health care • Enhance care coordination	-Primary Care Spending Report	Legislature in Session
Mar 6, 2018	• Supporting Health System Transformation: The Transformation Center • CCO 2.0 Workstream Review	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
April 3, 2018	• Workforce Committee Report on Health Care Provider Incentive Program • Action Plan for Health Update (tentative) • Opioid Crisis Discussion • CCO 2.0 Update	• Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		
May 1, 2018 (EXTENDED MEETING: 2 PM)	• PHAB Update & Presentation: baseline accountability metrics • HEC Update • Medicaid Advisory Committee (MAC) SDOH Update • CCO 2.0 Update	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		
June 5, 2018 (EXTENDED MEETING: 2:30 PM)	• HPQMC Update • CCO 2.0 Update & Draft Model Review	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		
July 10, 2018	• High Cost Drugs Update • CCO Metrics Report Review • CCO 2.0 Update	• Engage stakeholders and community partners • Pay for outcomes and value • Measure progress	-CCO Metrics Report -Hospital Transformation Performance Program Report	PHAB recommendations to OHPB re: Accountability Metrics. Due date is not in statute.

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
August 7, 2018	• Workforce Composition Promising Strategies & Presentation on Evaluation of Health Provider Incentives • CCO 2.0 Final Recommendations Review	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Hospital Financial Report	Workforce Financial Incentives Evaluation Report, due to interim health committees of the Leg. Assembly every 2 years, first due Sep. 2018. OHA report to OHPB re: Status of Doulas in Oregon Sep. 2018
September 7, 2018	• Action Plan for Health update • CCO 2.0 Finalization	• Engage stakeholders and community partners • Measure progress	-WF composition report	
October 2, 2018 **OUT OF AREA MEETING: HOOD RIVER (tentative)**	• Workforce Provider Incentive Program Update • Engaging Stakeholders & Partners Discussion	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress	-Oregon Health Insurance Survey Fact Sheets	
November 6, 2018	• Behavioral Health Collaborative Report • Primary Care Collaborative Update	• Pay for outcomes and value • Shift focus upstream • Improve health equity • Increase access to health care • Enhance care coordination • Engage stakeholders and community partners • Measure progress		Primary Care Collaborative Report

Month	Agenda Items (Chair's welcome, Director's report, public testimony and breaks are standing items; the Board may take action regarding committee membership and formation as needed)	Action Plan Foundational Strategies	Reports	Legislative Mandates
December 4, 2018	• Health Information Technology Oversight Council (HITOC) Annual Workplan Review	• Increase access to health care • Enhance care coordination • Engage stakeholders and community partners	-Hospital Community Benefit Report	Behavioral Health Collaborative final report due to JCW&M

Oregon Health Policy Board
DRAFT May 1, 2018
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Item	
OHPB video and audio recording To view the video, or listen to the audio link, of the OHPB meeting in its entirety click here. Agenda items can be reviewed at time stamp listed in the column below.	
Welcome and Call To Order, Chair Zeke Smith Present: Board members present: Chair Zeke Smith, Co-Chair Carla McKelvey, Oscar Arana, David Bangsberg, Brenda Johnson, John Santa, The Board voted to approve the April minutes and asked that time stamps be added to the document.	
Director's Report, Patrick Allen, OHA Pat Allen gave and update regarding the OHA reorganization at a high level and presented a high level functional organizational chart. OHA will return in June to confirm changes.	Part 1 00:13:00
OHPB Committee Liaison Update Each Board Member present gave a brief update on the committees they are the liaison for.	Part 1 00:41:30
Public Health Advisory Board (PHAB) Update, Carrie Brogoitti, PHAB Co-Chair, Rebecca Pawlak, PHAB Co-Chair Carrie and Rebecca gave an update on the work the PHAB committee has been doing. They shared a Public Health Accountability Metrics Baseline Report, discussed the framework for public health accountability metrics, shared various public health outcome metric measurements, discussed CCO 2.0 considerations and provided an update regarding public health modernization.	Part 1 01:34:49
Medicaid Advisory Committee (MAC): Social Determinants of Health, Laura Etherton, MAC Co-Chair, Amanda Peden, OHA, Health Policy	Part 1 02:50:35

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Laura and Amanda gave an update regarding the MAC's work around social determinants of health. They shared their recommendations with the board which included the committee timeline and definition for social determinants of health.	
Health Equity Committee (HEC) Workplan and Update, Carly Hood-Ronick. HEC Co-Chair, Michael Anderson-Nathe, HEC C0-Chair, Leann Johnson, OHA, Director Office of Equity & Inclusion The committee Co-Chairs and Leann gave an update regarding the work that HEC has been doing, a brief background on who they are, and how they would like to engage the work and Board going forward.	Part 2 00:00:21
CCO 2.0 Update, Steph Jarem, OHA, Health Policy Steph gave a brief update on CCO 2.0 development, survey results and timelines going forward.	Part 2 01:03:40
Public Testimony Micheal Eliason of the Association of Oregon Counties, shared recommendations regarding CCO 2.0 including requesting the Board continue to stay focused on key design elements of the model, including local flexibility to meet triple aim. He had specific recommendations regarding local public and behavioral health systems and they work with CCOs. Tricia Movtell of the Coalition of Local Health Officials, shared recommendations regarding CCO 2.0 and asked the Board to consider and align local public health services as they intersect with the delivery system. She referenced a letter submitted by the coalition and urged investments in public health for community based prevention and she noted the need for public health modernization, prioritizing upstream services to address cost drivers associated with tobacco use, obesity and other early intervention opportunities. Cherryl Ramirez, Director of the Association of Oregon Counties Mental Health Providers association and shared CCO 2.0 recommendations. She supported the testimony of Mr. Eliason and testified on behalf of 23 community mental health programs around the state. She noted AOCMHP will provide formal written recommendations and continue to provide feedback at later opportunities.	00:04:20

Oregon Health Policy Board
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Adjourn

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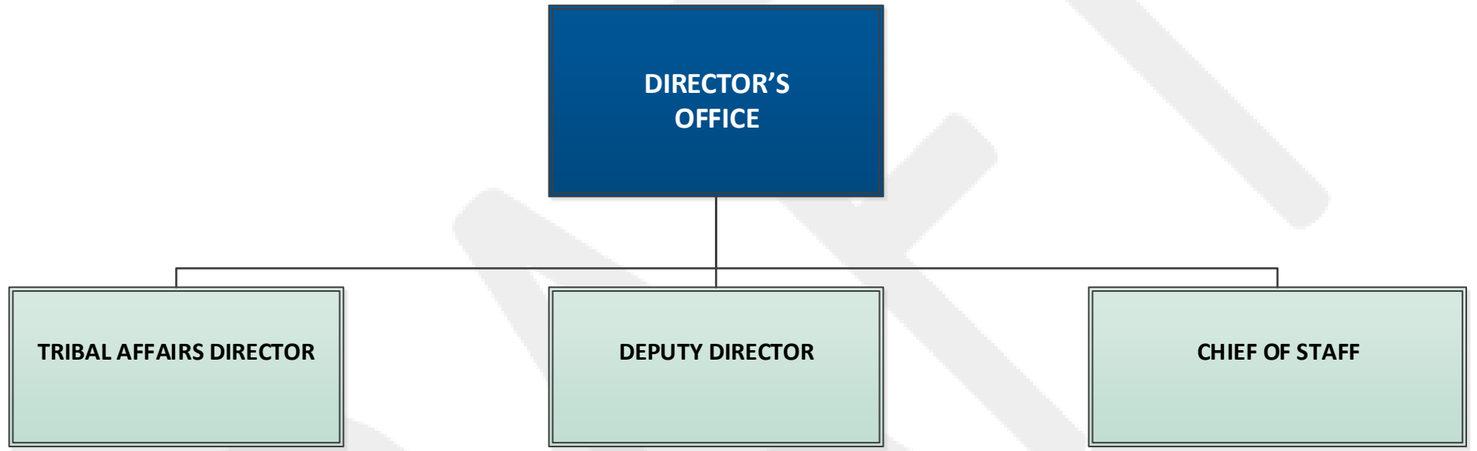
Oregon Health Authority
Functional Organizational Chart



OFFICE OF EQUITY & INCLUSION

- Compliance & Civil Rights
- Health Equity

OREGON STATE HOSPITAL

- OSH Salem
- OSH Chief Medical Officer
- Hospital Systems Analysis & Management
- OSH Chief Financial Officer
- Nursing
- Pendleton Cottage
- OSH Junction City

FISCAL

- Program Integrity
- Health Care Finance
- Budget
- Actuarial Services

AGENCY OPERATIONS

- Office of Information Services
- Office of Human Resources
- Central Operations

PUBLIC HEALTH

- Center for Public Health Practice
- Center for Prevention & Health Promotion
- Center for Health Protection
- Public Health Officer
- Policy & Partnerships
- Program Operations
- Fiscal & Business Operations

EXTERNAL RELATIONS

- Communications
- Government Relations
- Stakeholder & Member Support

HEALTH POLICY & ANALYTICS

- PEBB/OEBB
- Health Information Technology
- Delivery System Innovation
- Transformation Center
- Business Supports
- Health Analytics
- Health Policy

HEALTH SYSTEMS

- Medicaid
- Behavioral Health
- Quality & Compliance
- Business Operations
- Business Information Systems

*Proposed structure effective July 1, 2018

OFFICE OF THE DIRECTOR
Kate Brown, Governor

Oregon Health Authority

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www.health.oregon.gov

Memorandum

To: Zeke Smith, Chairman, Oregon Health Policy Board

From: Patrick M. Allen, Director, Oregon Health Authority

Date: May 31, 2018

Re: Agency realignment proposal

Background

In late April I proposed a realignment of the Oregon Health Authority organizational structure to consolidate Medicaid policy and operations, to consolidate behavioral health and to strengthen the services our agency provides to consumers and stakeholders.

As I said when I shared this proposal with you at your last meeting, these changes do not result in any layoffs, and no employee will have to relocate to a new job site. The purpose of these changes is to align our structure, improve our business rigor and strengthen transparency and accountability in our agency. I anticipate the new Medicaid director and the new Behavioral Health director, once they are hired, may revise the structure. We will begin recruiting for these positions once you approve this proposal.

Adjustments

I asked OHA staff, community partners and external stakeholders for input on my proposal. After reviewing the feedback, I have made some adjustments. The highlights include:

- Changing the name of the new Substance Use & Gambling Disorders unit to Addictions, Recovery & Prevention Services and aligning additional staff to sharpen the focus of this group's work in the new Behavioral Health Program.
- Creating a deputy director position in the new Behavioral Health Program and aligning behavioral health policy analysts to report to this position. This position will help manage this important work and will mirror the deputy director role in the new Medicaid Program.
- Aligning positions in the new Medicaid Program, such as the Integrated Eligibility team, to further consolidate policy and operations.

Request for approval

I am happy to answer any questions or concerns. Thank you in advance for your consideration.

OHPB Committee Digest

PUBLIC HEALTH ADVISORY BOARD, METRICS & SCORING COMMITTEE, HEALTH PLAN QUALITY METRICS COMMITTEE, HEALTH INFORMATION TECHNOLOGY OVERSIGHT COUNCIL, HEALTHCARE WORKFORCE COMMITTEE, HEALTH EQUITY COMMITTEE, PRIMARY CARE COLLABORATIVE, BEHAVIORAL HEALTH COLLABORATIVE, MEDICAID ADVISORY COMMITTEE, STATEWIDE SUPPORTIVE HOUSING WORKGROUP

Public Health Advisory Board

The PHAB has advised OHA on changes to the 2019-21 local public health authority funding formula, which OHA is required to submit to Legislative Fiscal Office in June 2018. The funding formula includes three components: a base amount, incentives for achievement of local public health authority accountability measures, and matching funds to encourage continued local investment in public health. The report to Legislative Fiscal Office will be presented to PHAB in early June and will include other information like how the current 2017-19 public health modernization investment is being spent, progress towards public health accountability measures, and priorities for the next phase of public health modernization.

The PHAB is hearing from each of the eight regions funded by the 2017-19 public health modernization investment to gain a better understanding of the systems changes underway to improve communicable disease control and address communicable disease-related health disparities.

Chair Smith had an opportunity to talk with PHAB members about how public health modernization can support health system transformation and CCO 2.0 as well as opportunities to improve consistency in efforts on the ground.

COMMITTEE WEBSITE: http://public.health.oregon.gov/About/Pages/ophab.aspx
COMMITTEE POC: Cara Biddlecom, Cara.M.BIDDLECOM@dhsoha.state.or.us

Behavioral Health Collaborative

Regional Behavioral Health Collaboratives (RBHC) Updates: OHA will be supporting the implementation of a regional behavioral health collaborative, as recommended by the BHC, in the Metro Portland tri-county area.
There are several reasons why we have decided on this path:

- FamilyCare's decision to leave the Oregon Medicaid market has illuminated the different approaches within the region's behavioral health system and the opportunity for our timely attention to address the ongoing challenges in this region.
- Willing partners who can readily mobilize to make decisive impact.
- As the primary population center of our state, the tri-county area gives us the opportunity to make a meaningful difference as well as learn valuable lessons to be replicated by other regions of the state.

Risk Sharing:
Risk sharing for the waitlist will be moved to CCOs in 2020. A variety of challenges make adding this to the 2019 amendment not possible. The workgroup meets on May 30 to continue discussing risk sharing options for the OSH civil commitment population.
Workforce:
Assessment of the behavioral health workforce, including licensed and unlicensed providers, is in process. OHA and the Addictions Counselor Certification Board of Oregon (ACCBO) are providing data for on the behavioral health workforce. The assessment is still in the data collection process and due to some data not being available until August 2018, the assessment will be completed in January 2019 with a recruitment and retention plan by March 31, 2019.
Standards of Care and Competencies:
OHA staff is consulting with the Farley Center from the University of Colorado to develop core competencies for an integrated behavioral health workforce.

COMMITTEE WEBSITE: https://www.oregon.gov/oha/amh/Pages/strategic.aspx
COMMITTEE POC: Jackie Fabrick Jackie.FABRICK@dhsoha.state.or.us

Primary Care Payment Reform Collaborative

The Primary Care Payment Reform Collaborative convened on April 19, 2018. Agenda topics of note included: review of the work plan and timeline for developing Primary Care Transformation Initiative implementation strategy from the Collaborative; *Primary Care Spending Report in Oregon* presentation followed by a discussion about how the report can inform the Primary Care Transformation Initiative; CCO 2.0 value-based payment and behavioral health presentation and discussion; and presentation on three options for evaluating the Primary Care Transformation Initiative followed by small group discussion. In May and June the workgroups will convene to draft a proposed Initiative implementation strategy for Collaborative review and discussion at the July meeting.

The Collaborative convenes next on July 24, 2018 from 9:00 a.m. – 12:00 p.m.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/Transformation-Center/Pages/SB231-Primary-Care-Payment-Reform-Collaborative.aspx.
COMMITTEE POC: Amy Harris, AMY.HARRIS@dhsoha.state.or.us

Healthcare Workforce Committee

The Healthcare Workforce Committee met on May 2, with 15 of 19 members participating.

The Committee received updates on recent activity of the Oregon Health Policy Board and on the Health Care Provider Incentive Program.

The Committee voted to approve revisions to its bylaws, that 1) Specifies members may serve two full terms of three years plus any partial term to which they are appointed; 2) Creates a new position of Immediate Past Chair, specifying duties of the position and changing the terms of the Chair, Vice-Chair and Immediate Past Chair to be one year; 3) Specifies that the Immediate Past Chair may serve on the

Committee for up to an extra year beyond the term dates to complete that accountability; and 4) Allow the bylaws to be amended with a 2/3 majority of a quorum of members present.

Committee members heard from the policy leads of each Policy Team for CCO 2.0 and offered feedback during the meeting and following the meeting. A letter approved by the Committee officially recommending items to require in the procurement process and during quarterly reporting was sent to OHA Director Pat Allen and OHPB Chair Zeke Smith.

Ongoing Activity:

A report identifying promising practices to increase diversity in the health care workforce will be developed between May and July and reviewed at the July Meeting.

Discussions with the Oregon Medical Board staff around improved data and data collections continue, with the objective of supporting the quality of information available in the Health Care Workforce Reporting Program.

The Committee will begin working on the 2019 Needs Assessment in July.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/HP-HCW/Pages/index.aspx
COMMITTEE POC: MARC OVERBECK, Marc.Overbeck@dhsoha.state.or.us

Health Plan Quality Metrics Committee

The Health Plan Quality Metrics Committee met on May 10th and approved the final aligned measures menu for 2019 state health care contracting. The Committee has reviewed 117 assorted health care quality measures since last July and approved 51 of the measures for inclusion on the measures menu. The Committee also identified twenty additional measurement topics that involve important aspects of health but where the Committee has of yet been unable to identify existing meaningful measures. These measurement topics will help guide the committee's future work to refine the measures menu with the aim of making it increasingly outcome-focused. In assessing the 51 quality measures included in the 2019 menu the Committee acknowledged that the available measures to date are heavily concentrated in prevention and early detection, with fewer measures addressing specialty care and health system integration and transformation. Other areas the Committee identified for near term focus include health equity, access to telehealth and other alternatives to face-to-face visits, obesity and upstream influences, and behavioral health.

As the Committee moves into the next phase of its work it will develop its work plan for the next 1-2 years, specifically considering how to best evolve the measures menu to advance measure alignment and adoption of evidence-based measures that promote desired outcomes. This will include examining approaches for creating new measures in areas of health where existing measures are inadequate. The committee next meets on Thursday June 14, 2018.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx
COMMITTEE POC: Margaret Smith-Isa, Margaret.G.Smith-Isa@dhsoha.state.or.us

Metrics & Scoring Committee

In April the Metrics and Scoring Committee discussed oral health measures and tentatively endorsed the inclusion of an EHR-based drug and alcohol screening and referral (SBIRT) measure in the 2019 CCO incentive measure set (though final decisions will occur in July).

In May the Committee welcomed new member, Dr. Amit Shah, as a CCO representative. The Committee also heard presentations on:

- The first Public Health Accountability report (discussing areas in which the Committee and the Public Health Advisory Board might support joint efforts on areas with shared metrics) and
- The PCORI behavioral health integration study from Providence's Center for Outcomes Research and Education (which has implications both for measures of integration, as well as patient experience).

In addition, the Committee discussed the prenatal/postpartum care measures and potential changes for the 2019 measure set.

At its next meeting on June 15th the Committee will further discuss oral health measures, and begin formal decisions regarding the 2019 incentive measure set. Final approval of the full 2019 measure set will occur in July.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx
COMMITTEE POC: Sara Kleinschmit, SARA.KLEINSCHMIT@dhsoha.state.or.us

Health Information Technology Oversight Council

HITOC's June meeting will feature additional CCO 2.0 policy proposals from the value-based payment and behavioral health workgroups, as well as revisit the HIT components being developed for CCO 2.0. HITOC will also consider the network of networks advisory group charter to begin foundational work to support statewide health information exchange, and hear about a proposed federal rule changing elements to the CMS Meaningful Use Program.

COMMITTEE WEBSITE: http://www.oregon.gov/oha/HPA/OHIT-HITOC/
Committee POC: Sean Carey, Sean.M.Carey@dhsoha.state.or.us

Medicaid Advisory Committee

- On April 25, 2018 the Medicaid Advisory Committee (MAC) approved a set of recommendations and report on addressing the social determinants of health (SDOH) through Oregon CCOs. The recommendations include:
  - Explanation of why it is important to address SDOH through Oregon CCOs
  - Standard definitions of SDOH and social determinants of health equity that can be used for all Oregon CCOs
  - A set of roles that CCOs as health care plans can play addressing SDOH
  - A set of general recommendations for CCOs when addressing SDOH

- On May 23, 2018, the MAC approved a second set of recommendations aimed at how OHA can support and hold CCOs accountable to addressing the social determinants of health, in line with the committee's recommendations to CCOs (above).
- The full set of recommendations will be submitted to the OHA by the end of the month.
- The next work product of the MAC will be a housing-specific guide on health-related services, to be developed in collaboration with OHA. The MAC will working with OHA to develop a guide that builds on feedback from the Statewide Supportive Housing Strategy Workgroup, its survey and follow up interviews with CCOs regarding work in the social determinants of health, and the evidence base around housing and health

COMMITTEE WEBSITE: http://www.oregon.gov/oha/hpa/hp-mac/pages/index.aspx
COMMITTEE POC: Amanda Peden, Amanda.m.peden@dhsoha.state.or.us

Health Equity Committee

HEC retreat debrief:
HEC members had the opportunity to reflect on the March retreat as a group. Consensus that retreat was well facilitated and provided an excellent space to deepen the relationships between members, an instance to clarify the committee's role, and how equity work at OHA needs to go beyond merely using a lens.
OHPB presentation debrief:
The co-chairs had an opportunity to share more on their presentation to the OHPB, including questions raised and discussion between co-chairs and Board members. Committee members in attendance also weighed in.
HEC Feedback to OHA on CCO 2.0
There was a conversation on formal feedback to OHA on CCO 2.0 and committee members requested that OHA CCO 2.0 policy leads come back to HEC and provide a follow up to the recommendations provided. The committee had the opportunity to provide direct feedback on the month of April to the Social Determinants of Health and Health Equity and Behavioral Health policy options. However, there was agreement from the group that a clearly defined detailed recommendation coming from the committee is essential because the HEC has expertise in this area and the input has great value. The committee will take the month of May to craft formal recommendations to OHA on CCO 2.0.
Committee governance:
The HEC has decided not to form an Executive Committee now due to attrition of members and with the desire to keep the group nimble and responsive to CCO 2.0 work. They will revisit Executive Committee formation in the future. In the interim, HEC will carry out their charge using ad hoc workgroups as they are more feasible and manageable at this point.
The following workgroups were established for the short term:
#1 Recruitment
This workgroup will work on HEC member recruiting process to fill the HEC committee to its full capacity.
#2 Strategic Plan Development/Work plan
This group will be charged with developing a HEC work plan for the remainder of 2018 and 2019. They will also draft a health equity framework for use by the committee and OHPB.
#3 Policy and Advocacy

This workgroup will be charged with identifying the process within OHA for building a legislative agenda and work to define an equity related legislative agenda for OHA to consider.
#5 Data and Metrics – This workgroup concept was of high interest/importance to several on the committee and ergo could potentially be committee wide.

COMMITTEE WEBSITE: N/A
COMMITTEE POC: Maria Castro, Maria.Castro@dhsoha.state.or.us

Statewide Supportive Housing Strategy Workgroup

This committee was formed in 2017 as a joint effort by Oregon Health Authority and Oregon Housing and Community Services to increase capacity for supportive housing across the state. It grew out of the prior work that was done to assess the inclusion of housing supports in the CMS 1115 waiver submitted by OHA in 2016 (housing was ultimately not included in that waiver submission).

Workgroup members are external partners from Coordinated Care Organizations, Community Mental Health Programs, Hospital Systems, Counties, Housing Authorities, Community Development Organizations, and a variety of community-based housing and behavioral health organizations. A roster is located at http://www.oregon.gov/ohcs/DO/sshwg/2017-2019-Member-Roster-Supportive-Supported-Housing-Workgroup.pdf

The SSHSW advises OHA and OHCS on key program and policy considerations and is developing an implementation framework to support both the housing services and health services needs of homeless individuals or individuals at risk of homelessness, the majority of whom have one of more chronic health conditions or disabilities. The recommendations to be made by SSHSW members may include a variety of components such as identified resource streams, a standard set of criteria for effective supportive housing and services, and what long-term technical assistance is needed for housing and health system partners.

COMMITTEE WEBSITE: http://www.oregon.gov/ohcs/Pages/supportive-housing-workgroup.aspx.
COMMITTTEE POC: Heather Gramp, Heather.Gramp@dhsoha.state.or.us

DRAFT 5-31-18

CCO 2.0 Policy Development
Draft Policy Options – For Review by OHPB 6/5/18

Following is a list of the guiding questions, policy goals or themes, and potential options and strategies that have been explored as part of the CCO 2.0 policy development process. These policies have been publicly reviewed by experts, stakeholders, and partners from January to May 2018, and public input has been incorporated whenever possible. This list will be discussed at the June 5 Oregon Health Policy Board meeting.

Behavioral Health

BH – Guiding Questions	Policy Options/Goals	Potential Strategies	Key
How will we measure integration?	Improve integration of behavioral health care by 1**) establishing a definition** of integration; 2) **identifying metrics** to track milestones of integration; 3) **identifying expected outcomes** and measures.	• OHA to refine definition of integration and add to the CCO contract • Identify metrics to track milestones of integration by completing an active review of each CCOs plan to integrate services that incorporates a score for progress • Increase technical assistance resources for CCOs to assist them in integrating care and meeting metrics.	∞
	Enhance electronic health record (**EHR)** and health information technology **(HIT) to improve integration**	• Develop an incentive program to support BH providers' investments in EHR • Require CCOs support EHR adoption across behavioral health contracted providers • Require CCOs ensure contracted BH providers have access to technology that enables sharing patient information for care coordination • Require CCOs ensure contracted BH providers have access to timely hospital event notifications, and require CCO utilization of hospital event notifications	♦
How can we encourage	**Implement Behavioral Health Home recognition program**.	• Identify, promote and expand programs that integrate primary care in behavioral health settings	5 ∞

5 = P-5 opportunity or focus ∞ = opportunity for standardizing ‡ = state or federal requirement
♦ = incentive pool impact * = impact on reporting/measurement

BH – Guiding Questions	Policy Options/Goals	Potential Strategies	Key
investment in behavioral health and hold CCOs accountable for these investments?	**Address billing barriers** between physical and behavioral health	• Identify billing system and policy barriers that prevent BH providers from billing from a physical health setting • Develop payment methodologies to reimburse for warm handoffs, impromptu consultations and integrated care management services • Examine equality in BH and PH reimbursement • Implement strategies from existing workgroups that are addressing integrated billing barriers	5
	Align CCO procurement process and contracting with Oregon Performance Plan (OPP), Behavioral Health Collaborative (BHC) and Medicaid Waiver	• Clear ownership of BH benefit by the CCO • OPP to be included in 2019 CCO contract extension • BHC alignment will include standardized assessments, workforce retention and recruitment, core competencies for workforce, risk sharing with Oregon State Hospital • Mental health residential benefit and capacity management	∞ * ‡
	Establish **care coordination standards for integrated care**	• Require CCOs to ensure a care coordinator is identified for individuals with Severe and Persistent Mental Illness (SPMI) and for children with Serious Emotional Disturbances (SED) • Develop standards for care coordination • Establish outcome measure tool for Care Coordination	5 ∞ *
	Direct service providers are using **evidence-based practices and emerging practices**	• Update OHAs recommended clinical practices • Require outcome measures or metrics for research based practices • CCOs provide clinical trainings or funding to their provider network • Incentivize use of best practices and emerging practices	∞ *
How can we ensure that the system has the workforce to achieve expected outcomes?	Identify and implement culturally and linguistically specific best practices to ensure **access to and utilization of culturally and linguistically specific programs**	• Implement the Behavioral Health Collaborative recommendations: assessment of the BH workforce; update BH Mapping tool; recruitment and retention plan; competencies for integrated BH workforce; standardized suicide risk assessment • Require CCOs develop best practices to outreach to culturally specific populations • Develop a diverse behavioral health workforce who can provide culturally and linguistically appropriate care	5 ∞

5 = P-5 opportunity or focus ∞ = opportunity for standardizing ‡ = state or federal requirement

♦ = incentive pool impact * = impact on reporting/measurement

BH – Guiding Questions	Policy Options/Goals	Potential Strategies	Key
		• Implement the recommendations of the Traditional Health Workers Commission	
How do we ensure that children receive comprehensive behavioral health services no matter where they live in Oregon?	Ensure access to a behavioral health **continuum of care across the lifespan**	• Prioritize access to early intervention (0-5) • Develop mechanism to assess adequacy services across the continuum of care • Require CCOs ensure gaps in the continuum of care are addressed and that consumers have access to a diverse provider network	5 ∞
	Ensure there are ample incentives and opportunities to **work across systems**	• System of Care to be fully implemented for the children's system • Require Wraparound is available to all children and young adults who meet criteria • Incentivize CCOs to develop approaches to meeting the complex health needs of children and young adults	5 ∞
	Ensure there is a children's behavioral health system to **achieve measurable symptom reduction**	• CCOs require outcome measures tools from providers and have the ability to collect and report out on data • Fund CCOs for prevention services for children • OHA and CCOs develop a Train the Trainer investment in behavioral health models of care • CCOs, with the support of OHA, to incentivize providers to implement trauma informed care practices	5 *
	Ensure **special populations**, prioritizing children in Child Welfare, have their physical and behavioral health needs met by CCO and system of care	• Enforce contract requirement for care coordination for all children in Child Welfare, state custody and other prioritized populations (I/DD) • CCOs require providers to utilize ACEs score or trauma screening tools to develop individual service and support plans	5 ∞

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Social Determinants of Health and Health Equity

Health Equity/SDOH Questions	Policy Options/Goals	Potential Strategies	Key

How can OHA encourage CCOs to spend more in social determinants of health & health equity work, and hold CCOs accountable for their spending?	**Increase strategic spending by CCOs on social determinants of health and health equity/disparities** in communities, including encouraging effective community partnership.	• Implement HB 4018: Require CCOs to spend portion of savings on SDOH, population health policy and systems change & health equity/health disparities, consistent with the CCO community health improvement plan (CHP)
		  • Require CCOs to hold contracts with and direct portion of required SDOH&HE spending to SDOH partners through transparent process
		  • Require CCOs to designate role for CAC
		• Years 1 & 2 infrastructure grants: State provide two years of "seed money" to help CCOs meet spending requirement on SDOHE in partnership with community SDOH and CHP providers
		  • Require one statewide priority – housing-related supports and services – plus community priority(ies)
			5
			♦
			*
			‡

	Increase strategic spending by CCOs on health-related services (HRS) as a mechanism to invest in the social determinants of health and equity in communities.	• Encourage HRS community benefit initiatives to align with community priorities, such as those from the Community Health Assessment and Community Health Improvement Plans • Require CCOs' HRS policies to include a role for the CAC in making decisions about how community benefit HRS investments are made.	5 *
	Increase CCO's focus on SDOH and equity and **ensure community partners are engaged and resourced to support** this focus.	• Encourage adoption of SDOH, Health equity, and population health incentive measures to the Health Plan Quality Metrics Committee and Metrics & Scoring Committee for inclusion in the CCO quality pool • Encourage CCOs to share financial resources with non-clinical and public health providers for their contributions to incentive measures, through clarifying the intent that CCOs offer aligned incentives to both clinical AND non-clinical providers with quality pool measure areas	5 ♦ ∞ *

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Health Equity/SDOH Questions	Policy Options/Goals	Potential Strategies	Key
	Provide clear, common definition of social determinants of health, health equity, and related concepts to ensure clear boundaries for CCO spending and engagement in these areas.	• Consider, adopt and operationalize definitions of social determinants of health and social determinants of health equity, as developed by the Oregon Medicaid Advisory Committee • Work with the OHPB Health Equity Committee to consider/develop definitions of health equity and health disparities	∞
How do we strengthen CCO partnerships and ensure meaningful engagement to support social determinants of health & health equity work?	**Strengthen Community Advisory Council (CAC)/CCO partnerships** and ensure **meaningful engagement of diverse consumers** to support social determinants of health & equity work.	• Require CCOs to align CAC member composition with demographics of Medicaid members in their communities, report to OHA, and explain barriers to and efforts to increase alignment • Require CCOs to report CAC member representation alignment with CHP priorities (e.g. public health, housing, etc.) and percentage of CAC comprised of OHP consumers • Require CCOs share with OHA (to be shared publicly) a clear organizational structure that shows how the CAC connects to the CCO board • Require CCOs have 2 CAC representatives, at least one being an OHP consumer, on CCO board	5 ∞ *
	Improve health outcomes through community health assessment **(CHA)** and community health improvement plan (**CHP) collaboration and investment.**	• Require CCOs to develop shared CHAs with local public health authorities and non-profit hospitals • Require CCOs to collaborate with local public health authorities and non-profit hospitals to develop shared CHPs to the extent feasible • Ensure CCOs include organizations that address the social determinants of health and health equity in the development of the CHA/CHP • Require CCOs to submit their CHA to OHA • Require that CHPs address at least two State Health Improvement Plan (SHIP) priorities, based on local need	5 ∞ *
How do we better ensure provider	Development of **CCO internal infrastructure and investment** to coordinate and support CCO equity activities and build	• Each CCO will establish permanent structures to advance health equity, including: • Single point of accountability for health equity with budgetary decision making authority and health equity expertise.	5 ∞ *

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Health Equity/SDOH Questions	Policy Options/Goals	Potential Strategies	Key
cultural competency, language accessibility, a diversified workforce, and access to critical services across the state within a CCO and its provider network that reflects the population served by the CCO?	organizational capacity to advance health equity.	• Adoption of a Health Equity plan to institutionalize organizational commitment to health equity. • Organization-wide cultural responsiveness and implicit bias training fundamentals training plan and timeline for implementation	
	Enhance **integration and utilization of Traditional Health Workers** to ensure delivery of high quality, and culturally and linguistically appropriate care to improve health outcomes	• Implement recommendations of the THW Commission, including requiring CCOs to: • Create plan for integration and utilization of THWs • Incorporate alternative payment methods to establish sustainable payment rates for THW services • Integrate best practices for THW services in consultation with THW commission • Designate a CCO liaison as a central contact for THWs • Identify and include THW affiliated with organizations listed under ORS 414.627 in the development of CHAs and CHPs	5 ∞ *
	Reduce barriers to access for health services through **standardization of telehealth reimbursement requirements** across all CCOs.	• Require CCOs to reimburse for telehealth services, including two-way video conferencing and asynchronous methods if certain conditions are met • Require reimbursement regardless of patient being in a rural or urban setting	5 ∞
What changes in data collection/use can we make to improve our understanding of social determinants of health & equity initiatives and disparities?		To be determined during Phase 2 and 3 of CCO 2.0 Policy Development Timeline (June-November 2018) based upon further development and planning related to recommended strategies above.	5 ∞ *

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Cost Containment and Sustainable Spending

Guiding Questions:

- Is 3.4% still the proper growth target for the entire CCO 2.0 contract period?
- What cost drivers threaten achievement of sustainable growth rate (3.4%) in future years?
- What cost drivers warrant additional analysis to help OHA and CCO partners continue to meet growth targets?
- What strategies could increase CCO financial accountability while preserving flexibility to operate within global budget?

Cost - Policy Categories	Policy Goals	Potential Strategies	Key
Spending Targets and Cost Containment	Maintain an aggressive spending target in CCO contracts and promote cost containment by sharing savings with CCOs	1. Ongoing evaluation of Oregon's sustainable spending target based on national trends and emerging data 2. Shared-savings arrangements for achievement of lower-than-targeted spending growth • Designed in part to ensure CCOs have funding stream to continue investments that reduce underlying health care spending 3. Include sustainable growth target as a contract requirement to increase CCO accountability	
Promoting Efficiency and High Value Care	Overall policy goal: Incentivize CCO efficiency and promote the use of health care services with highest clinical value ***Supporting rationale:*** *Payments to CCOs,*	1. Evaluate efficiency and total costs of care to establish variable profit margins based on CCO performance • Potential tools include using episode groupers to evaluate care for specific conditions to identify waste and inefficiency in the system and using "total cost of care" tools to evaluate costs and service intensity/utilization across the system and compared to multiple benchmarks	

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	hospitals and other providers should reward and incentivize efficient delivery of care and use of services with highest clinical value	2. Incentivize health care services with highest clinical value by rewarding their use in rate setting • Identify health care services and bundles of care with highest and lowest clinical value through formal process that builds on our prioritized list • Give additional "credit" in capitation rate setting for higher clinical value care and less credit for lower-value services. o High value examples: medication-assisted treatment for opioid use disorder, diabetes prevention programs, integrated behavioral health, contraceptive placement, breastfeeding counseling & supplies, and tobacco cessation o Low-value examples: opioid use treatment w/o medication, stress tests in stable coronary disease, elective orthopedic surgery, and inappropriate tests and/or screenings outside clinical guidelines. 3. Increase the portion of hospital payments that are based on quality and value • Incorporate quality and value measures in calculating reimbursement to hospitals (includes CCO and OHA directed payments).	
Quality Pool Payments & Structure	Incentivize CCOs to invest quality pool funds on programs, providers and partners that improve quality and enable CCOs to achieve selected metrics, while ensuring accountability and reducing cost growth	1. Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development in order to: • Align incentives for CCOs, providers, and communities to achieve quality metrics • Create consistent reporting of all CCO expenses related to medical costs, incentive arrangements, and other payments regardless of funding source (Quality Pool or global budget)	

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Mitigating Financial Risk & Outlier Costs	Spread and manage risk related to low frequency, high-cost conditions and treatments	1. Establish a statewide reinsurance pool for CCOs administered by OHA to spread the impact of low frequency, high cost conditions and treatments across entire program 2. Expand / revise existing risk corridor programs • Value potentially limited to targeted conditions and/or services 3. Address increasing pharmacy costs and the impact of high-cost and new medications • Ongoing policy development & follow-up based on future OHPB committee	
Financial Reporting and Reserves	Enhance alignment of CCOs risk and financial requirements to ensure CCO solvency, accountability, and consistency of data	2. Enhance current reporting tools: A. Building on existing reporting templates (i.e., Exhibit L) and reevaluate reserve requirements and calculations to better account for risks CCOs bear o Home-grown and flexible to meet needs of CCOs with varying structures o Reconciliation to rate-setting process incorporated in reporting o Consistency across CCOs can be lacking due to inherent flexibility B. Move to reporting standards used by commercial insurers and developed by the National Association of Insurance Commissioners (NAIC) and use Risk Based Capital (RBC) approach to evaluate solvency o NAIC provides consistent national standards used by many insurers o RBC provides robust oversight framework o Additional reconciliation needed to inform CCO rate development C. Combination approach if possible 3. Create a statewide reserve pool in addition to CCO-specific reserve requirements in the event of an insolvency • Such a pool could avoid the need to CCOs receive additional funding to build up reserves, but could require up-front state funds.	

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Ensuring Accurate and Sufficient Encounter Data	Consistent and accurate reporting of services provided and their associated costs	1. Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy (AZ Model) with financial implications • Goal is to ensure the accuracy of encounter data, which is an important tool for the development of actuarially sound capitation rates for CCOs 2. Require complete encounter data with contract amounts and additional detail for value-based payment arrangements • With greater use of value-based payments and other alternative payment methodologies, new tools will be needed to ensure rate development processes take into account the services provided and the underlying costs of those services. • In absence of additional reporting, proxy values must be used and may not be as accurately reflective of the costs/value of services provided	

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Value-based Payments

VBP Guiding Questions	Policy Options/Goals	Potential Strategies	Key
How can OHA use VBP targets to encourage VBPs between CCOs and their providers, and hold CCOs accountable? *CCO payments to providers: Targets*	Increase **CCOs' use of VBPs with their contracted providers**	• Require CCOs to develop Patient-centered Primary Care Home VBPs (i.e., payments based on PCPCH tier level) • Require CCO-specific VBP targets in support of achieving a statewide VBP goal	∞ *

How can OHA encourage VBPs that foster improvements in key care delivery areas to achieve better health outcomes?
CCO payments to providers: Policy areas
	Increase the use of **VBPs to improve health outcomes** in key care delivery areas	• Require CCOs to implement one VBP focused on these key care delivery focus areas:
		  • Primary care
		  • Behavioral health integration
		  • Oral health integration
		  • Specialty care
		  • Hospitals
		  • Children's health care
		  • Maternity care
		• Publish CCO data on these VBPs
		• Provide technical assistance to CCOs
		• Potentially develop more robust VBP requirements in later years
			5
			♦
			∞
			*

What changes to data collection are necessary to track progress on, and improve our	**Assess CCOs' progress** toward the statewide VBP	• Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting • Streamline reporting by using All Payer All Claims (APAC) database for VBP reporting	∞ *

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VBP Guiding Questions	Policy Options/Goals	Potential Strategies	Key
understanding of, VBP utilization? *CCO payments to providers: Data*	goal and CCO-specific VBP targets	• APAC already collects non-claims payments from commercial carriers. Modifying APAC to better align with the VBP effort and having CCOs report to APAC will allow for comparing VBP progress across the health system, including CCOs. • Collect supplemental data and / or interviews • Information not captured in quantitative data collection such as how CCOs' are addressing racial/ethnic health disparities, what informed their models, longer term VBP goals, etc.	

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Oregon Health Policy Board

June 5, 2018

What is CCO 2.0?

- Coordinated Care Organizations (CCOs) coordinate care for members on the Oregon Health Plan. They started in 2012 with the goal of achieving the Triple Aim:
  - Better care
  - Better health
  - Lower health care costs

- Lots of data have been collected over the past five years (CCO 1.0) on:
  - What CCOs are doing well
  - What CCOs need to improve on
  - What gaps we still have in data

- CCO 2.0 = in the next 5 year contract we have the chance to change requirements, reward CCOs in new ways, and test out new ideas.

Goals for today:

- Present information on potential policy options in each CCO 2.0 topic area

- Solicit feedback from the Board:
  - Throughout policy presentations:
    - Questions, comments and concerns
    - Initial reactions
  - During debrief:
    - Overall reactions
    - Plan for June-August

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Policy Development process

- Created policy questions from looking at data from first five years of CCOs
- Policy options drawn from previous work, existing recommendations and research into best practices
- Policy options included thus far have focused on potential feasibility, readiness, impact, and timelines
- Input and feedback gathered via public engagement

Expectations

- Each topic area will share:
  - Existing challenges in the system
  - Policy options that could improve CCOs
  - Public input received on these policy options

- To note:
  - More technical descriptions of the policy options/strategies on the accompanying handout
  - Public comment and input on policy ideas was incorporated already whenever possible

CCO 2.0: BEHAVIORAL HEALTH

Oregon Health Policy Board Presentation

Mike Morris, Behavioral Health Policy Administrator
Jackie Fabrick, Behavioral Health Policy Analyst

June 5, 2018

Oregon Health Authority

HEALTH POLICY
Health Policy and Analytics

Behavioral Health in CCO 2.0:

Policy development topic area team

Project management and policy lead staff	Royce Bowlin, Behavioral Health Policy Nicole Corbin, Health Systems Division Jackie Fabrick, Behavioral Health Policy Lea Forsman, Health Systems Division Chelsea Holcomb, Health Systems Division Mike Morris, Behavioral Health Policy Chris Norman, Health Systems Division
OHPB policy liaison	Lori Kelley, Office of Health Policy
Additional subject area experts	Jon Collins, Office of Health Analytics Chelsea Guest, Actuarial Services

Problem statement

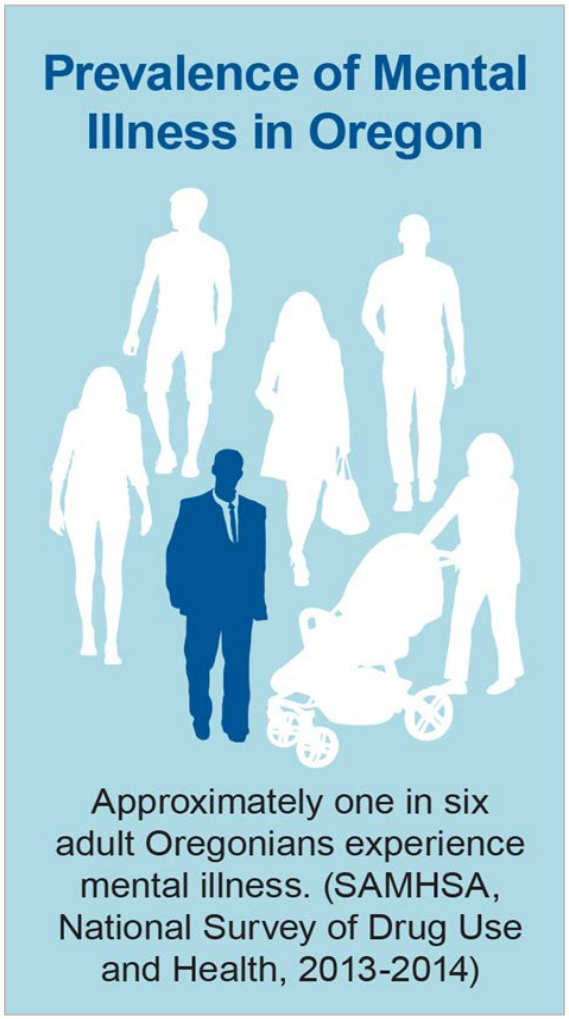
"The behavioral health system as a whole continues to include fragmented financing, carve-outs that prevent integration and efficiencies, siloed delivery systems, and services that fail to serve and exacerbate poor health outcomes"

– Behavioral Health Collaborative Report

Jane's story

- 22 year-old female
- English is her second language
- Working part-time
- Lives in rural Oregon
- Diagnosed with bipolar disorder at 16
- Managing meds with primary care provider (PCP)

A behavioral health system that works for all Oregonians



- Services should be accessible
- No wait time for services
- Consumers should have choice in who they see for services
- Services should be integrated
- Consumers have their needs met without having to navigate the system
- **The right services, at the right place, at the right time**

Examples of where this is working

Options for Southern Oregon

- CCBHC and PCPCH Tier 5 Star
  - *Certified Community Behavioral Health Clinic (CCBHC)*
  - *Patient-Centered Primary Care Home (PCPCH)*
- Behavioral health providers in external primary care
- Peers part of treatment teams
- Collaborative with DHS Child Welfare
- Colocation with community partners: community college, juvenile center, schools, Head Start programs
- Open access through telehealth

Examples of where this is working

Virginia Garcia

- Tier 5 Star PCPCH
- School based health clinics
- Medication assisted treatment
- Open access
  - Increased patient reach from 9% to 14% by changing the dynamic and reframing the role of the behavioral health provider

Examples of where this is working

Springfield Family Physicians and Center for Family Development Tier 5 Star PCPCH

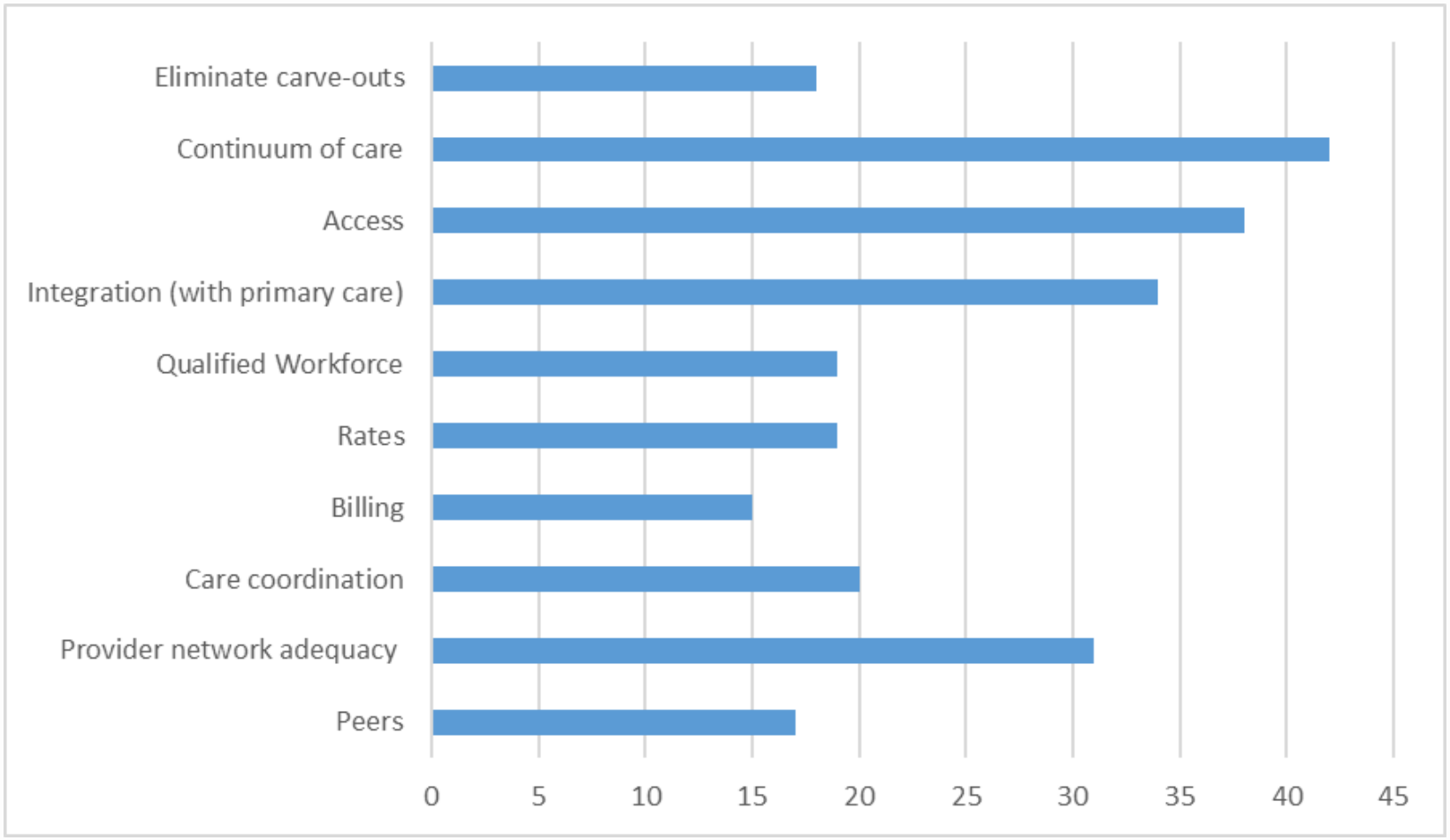
"We have normalized behavioral health inside of primary care. In many ways removing the stigma of people seeking out behavioral health. And we have come a long way in how physical health understands the extremely important role that behavioral health plays in treating conditions physicians see every day." – Jane Conley, Springfield Family Physicians

"Primary care providers say they would never want to work without behavioral health." – Megan Post, Center for Family Development

BH Public Input Activities to date

- Addictions and Mental Health Planning and Advisory Council (AMHPAC)
- Association of Oregon Community Mental Health Programs
- Oregon Consumer Advisory Council (OCAC)
- Oregon Association of Hospitals (OAHHS) BH committee
- Traditional Health Workers Commission
- CCO Leadership meeting
- Medicaid Advisory Committee (MAC)
- OHPB Healthcare Workforce Committee (HCWF)
- Oregon Prevention Education & Recovery Association(OPERA)
- Children System Advisory Council (CSAC)
- AMHPAC, OCAC, THW Commission Webinar
- OHPB Health Information Technology Oversight Council (HITOC)
- National Alliance on Mental Illness Oregon (NAMI)
- + survey and four forums

Stakeholder Feedback



Three Key Stakeholder Themes for Improving Behavioral Health

- Behavioral health **integrated** with physical health
- **Provider network** that meets the needs of our members
- **Access** to the right services, in the right place, at the right time

Behavioral Health Integration

Accountability

- OHA to refine definition of integration
- Identify metrics to track milestones of integration
- Increase technical assistance resources

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Behavioral Health Integration

Behavioral Health Home recognition program

- Identify, promote and expand programs that integrate primary care in behavioral health settings

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Behavioral Health Integration

Care coordination

- Require CCOs to ensure a care coordinator for individuals with Severe and Persistent Mental Illness (SPMI) and for children with Serious Emotional Disturbances (SED)
- Develop standards for care coordination
- Establish outcome measure tool for care coordination

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Behavioral Health Integration

Electronic health record (EHR) and health information technology (HIT)

- Develop incentive program
- Require CCOs support EHR adoption
  - Ensure BH providers have access to HIT and hospital event notifications
- Require CCO utilization of hospital event notifications

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Behavioral Health Integration

Address billing barriers (OHA)

- Identify billing and policy barriers that prevent BH providers from billing from a physical health (PH) setting
- Develop additional payment methodologies to reimburse
- Examine equality in BH and PH reimbursement

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Behavioral Health Integration

Use evidence-based practices and emerging practices

- OHAs recommended clinical practices
- Require outcome measures or metrics for research-based practices
- CCOs provide clinical trainings or funding to their provider network
- Incentivize use of best practices and emerging practices

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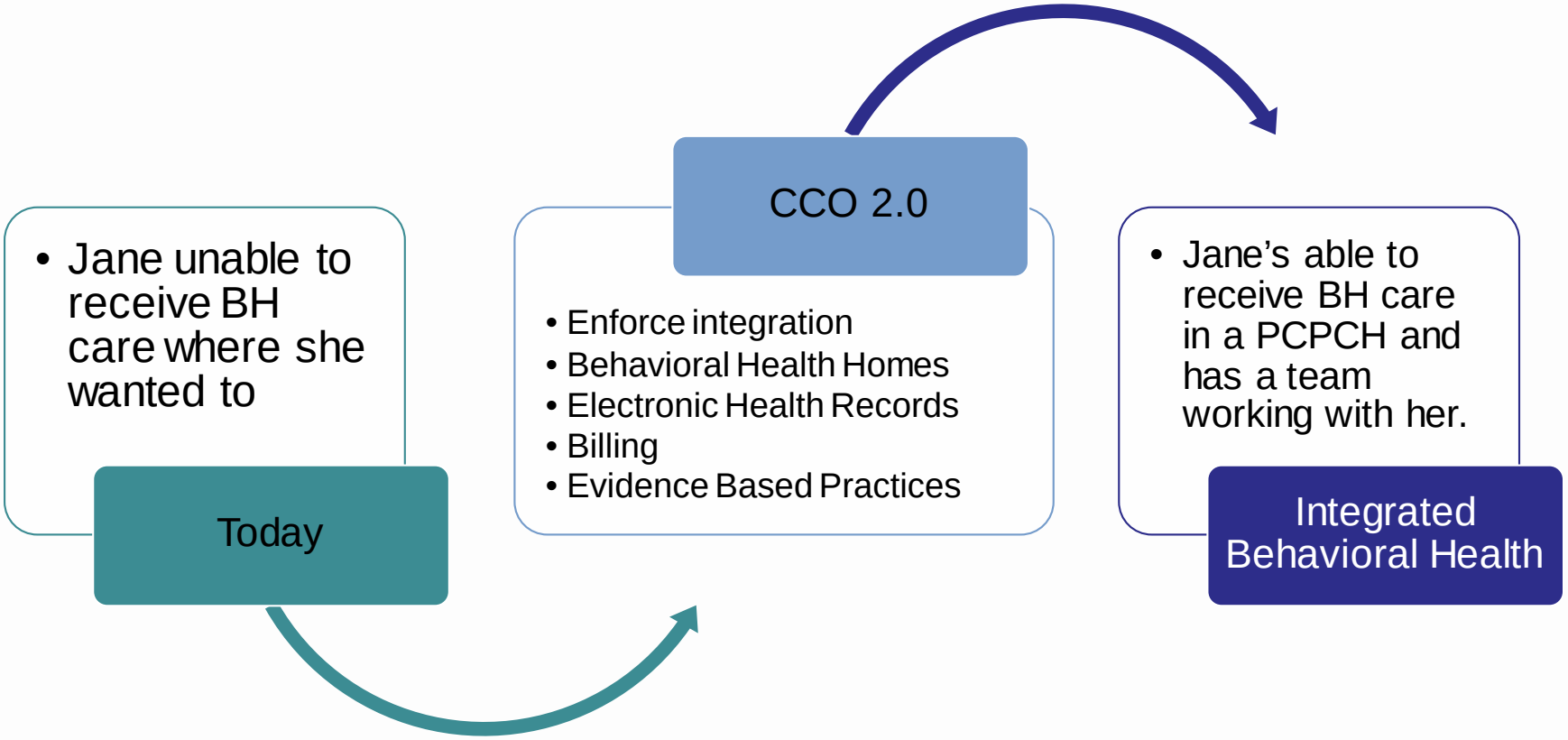
What does this mean for Jane?



Access to Services

Align CCO procurement process and contracting with Oregon Performance Plan (OPP), Behavioral Health Collaborative (BHC) and Medicaid Waiver

- Clear ownership of BH benefit by the CCO
- OPP to be included in 2019 CCO contract extension
- Risk sharing with Oregon State Hospital
- Mental health residential benefit and capacity management

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Access to Services

Ensure access to a behavioral health continuum of care across the lifespan

- Prioritize access to early intervention (0-5)
- Adopt mechanism to assess the adequacy of services across the continuum of care
- Require CCOs ensure gaps in the continuum of care are addressed and that consumers have a access to a diverse provider network

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Access to Services

Ensure there is a children's behavioral health system to achieve measurable symptom reduction

- CCOs require outcome measures tools from providers
- CCOs invest in prevention services for children
- OHA and CCOs develop a Train the Trainer investment in behavioral health models of care
- CCOs, with the support of OHA, invest in and support providers to implement trauma informed care practices

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Access to Services

Ensure special populations have their physical and behavioral health needs met by CCO and system of care, prioritizing children in Child Welfare

- Enforce contract requirement for care coordination for all children in Child Welfare, state custody, and other prioritized populations (I/DD)
- CCOs require providers to utilize ACEs score or trauma screening tools to develop individual service and support plans

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Access to Services

Provide ample incentives and opportunities to work across systems

- System of Care to be fully implemented
- Require that Wraparound is available to all children and young adults who meet criteria and fully fund
- Incentivize CCOs to develop approaches to meet the complex needs of children and young adults

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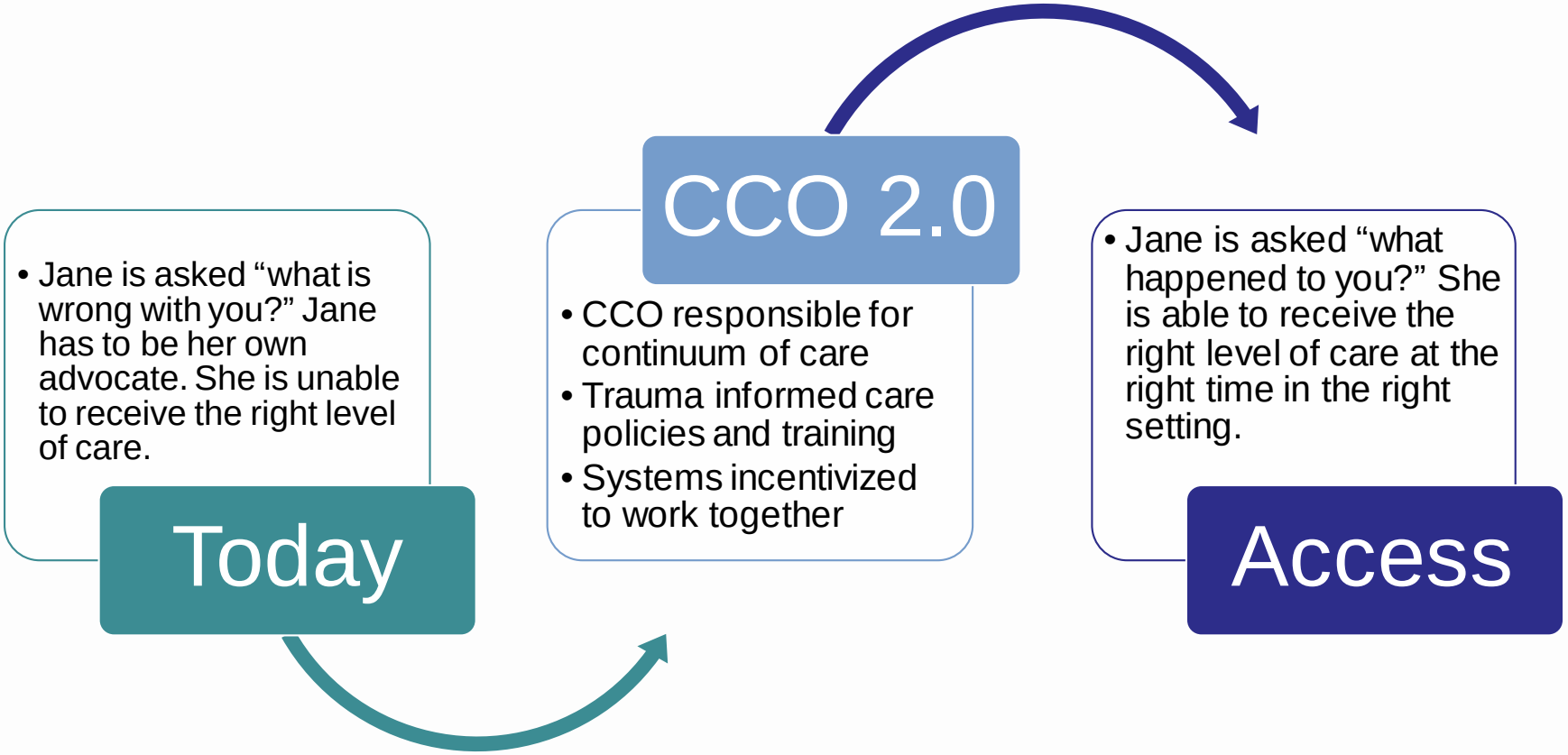
What does this mean for Jane?



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Provider Network

Implement the Behavioral Health Collaborative workforce recommendations

- Assessment of the BH workforce
- Update BH Mapping Tool
- Recruitment and retention plan
- Competencies for an integrated BH workforce
- Standardized suicide risk assessment

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Provider Network

Increase access to culturally and linguistically specific best practices

- Require CCOs develop best practices to reach culturally specific populations
- Develop a diverse behavioral health workforce who can provide culturally and linguistically appropriate care
- Implement the recommendations of the Traditional Health Workers Commission

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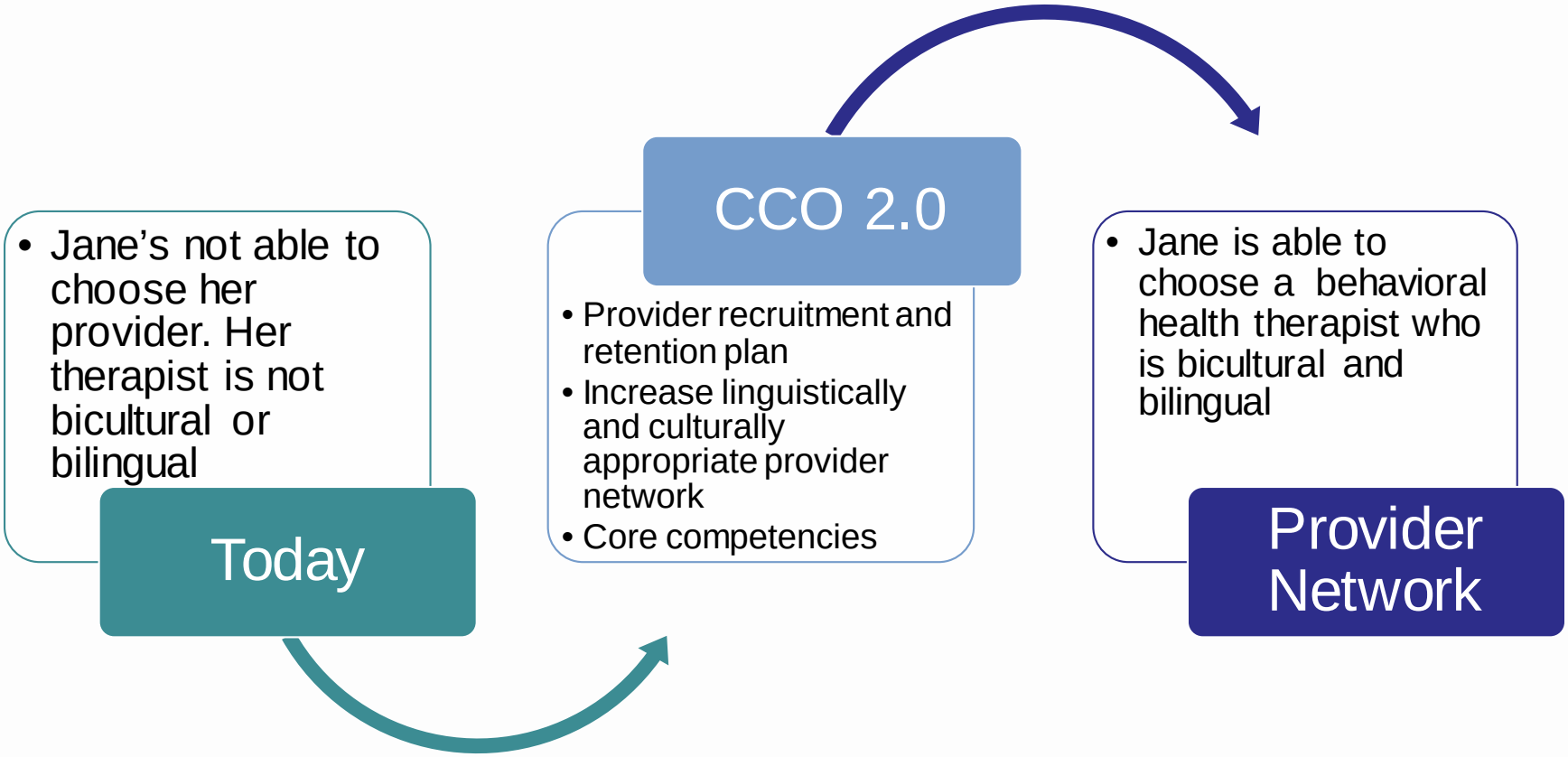
What does this mean for Jane?



Summary

Oregonians can have access to high-quality behavioral health services at the right place at the right time:

- Integration of behavioral health into physical health care
- Address billing barriers
- CCOs ensure full continuum of care
- Recruit and retain a workforce prepared for integrated settings
- Ensure culturally and linguistically appropriate services
- Hold CCOs accountable for the behavioral health benefit

Questions

- What reactions do you have to the overall package of policies?
- Are there policy areas that you would like to prioritize at this time?

Thank you!

CCO 2.0: The Social Determinants of Health & Health Equity

HEALTH POLICY
Health Policy and Analytics

Policy Development Topic Area Team

Leads and Subject Matter Experts	Leann Johnson, Office of Equity and Inclusion Chris DeMars, Transformation Center
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Today's goals

- Illustrate the relationship between Social Determinants of Health & Health Equity and the connection with CCO 2.0 policies
- Share feedback from public input sessions which informed potential CCO 2.0 policy strategies
- Introduce Social Determinants of Health and Health Equity CCO 2.0 policy strategies through the lens of a hypothetical member story

What are social determinants of health and health equity?

Health equity

Means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing economic and social obstacles to health such as poverty and discrimination

(RWJF)

Social Determinants of Health (SDOH)

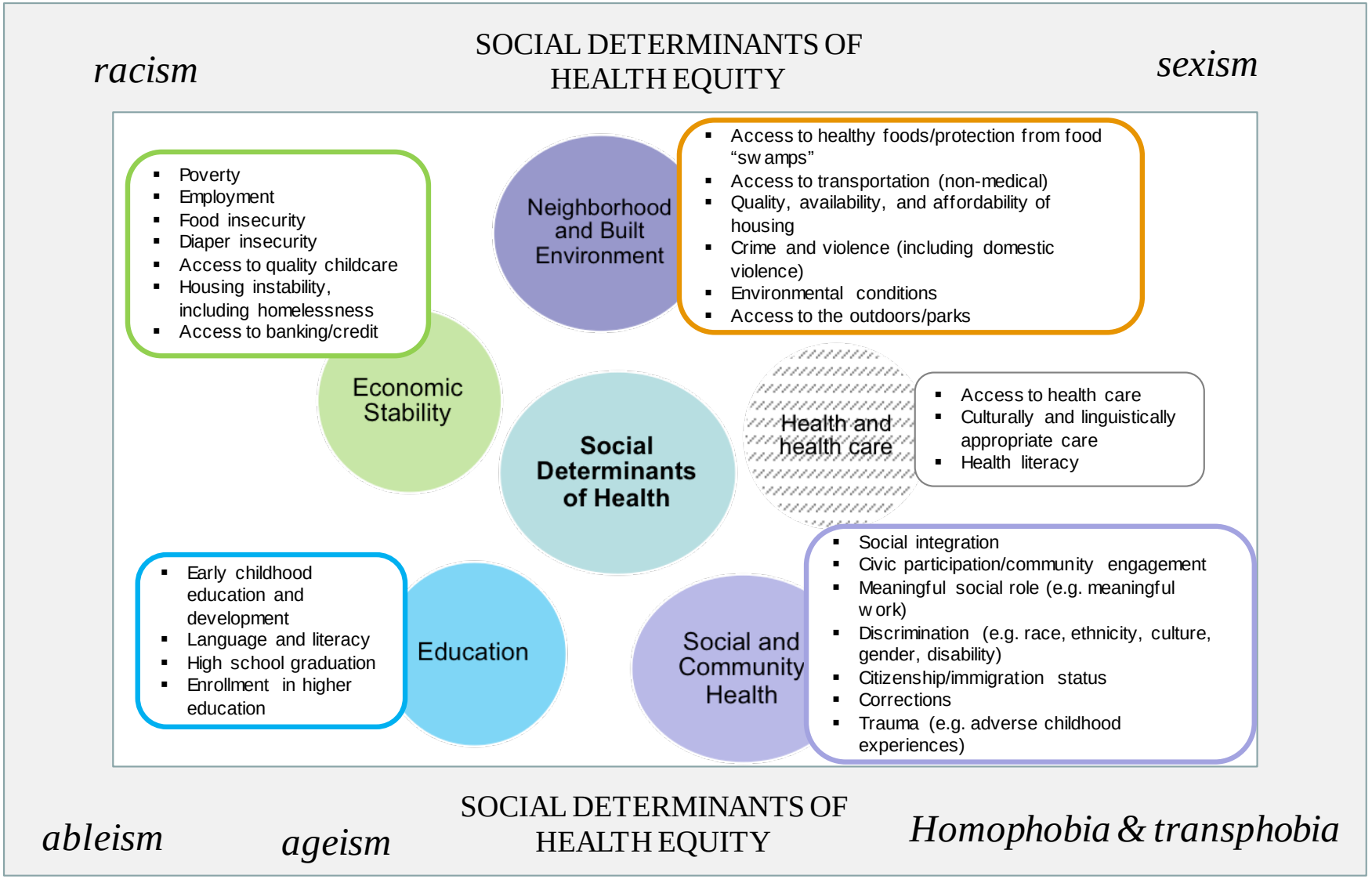
Are the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. (Oregon Medicaid Advisory Committee – "MAC")

The Social Determinants of Health Equity

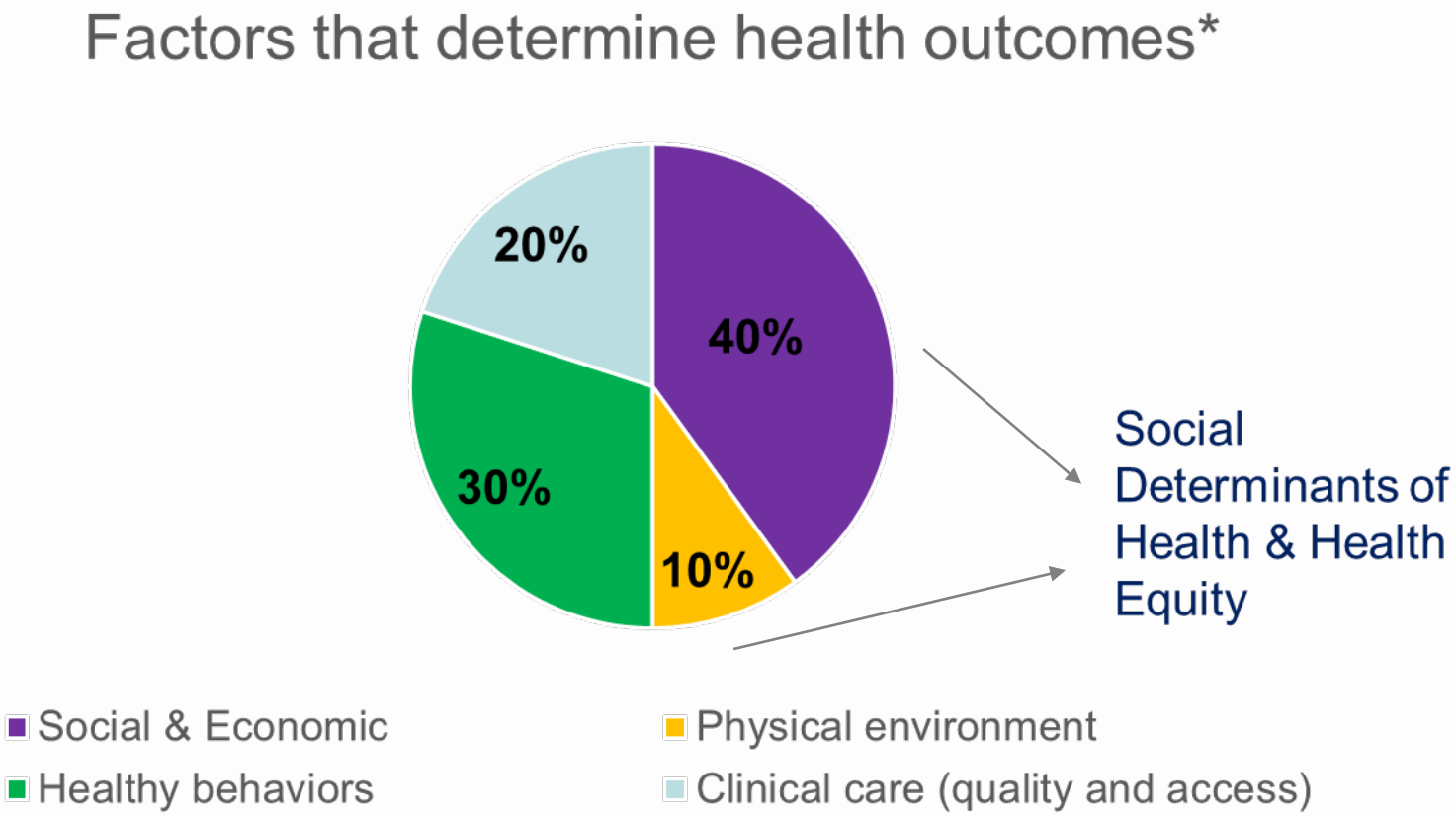
Are systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies, and political systems, both historical and current. Institutionalized racism is one example. (MAC)

Social Determinants of Health & Health Equity Factors

(MAC Approved 4/25/2018)

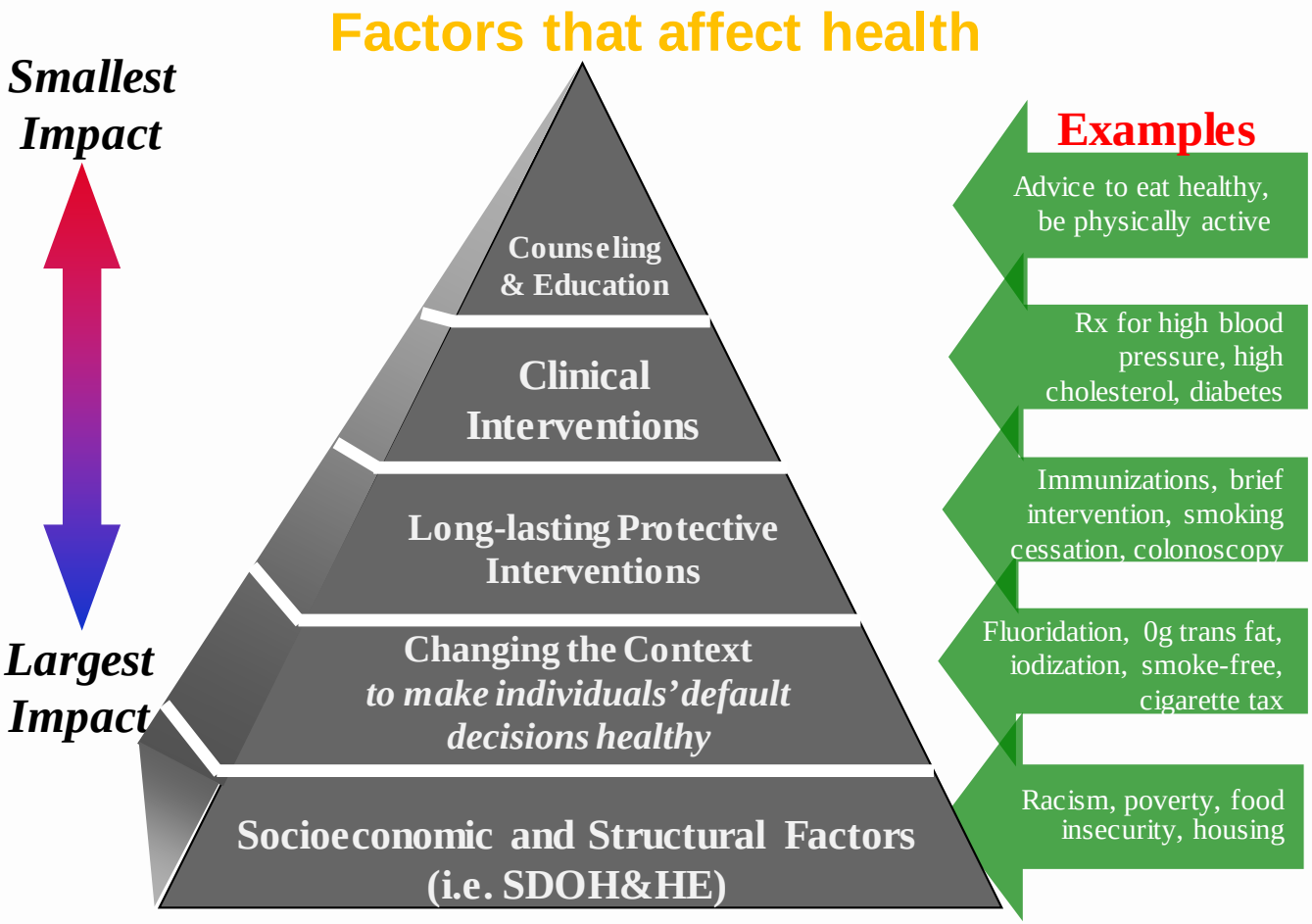


Why are the social determinants of health and health equity so important?



Source: County Health Rankings Model. University of Wisconsin Public Health Institute. 2014. *This model does not include biology/genetics.

What work can impact the social determinants of health and health equity?



Strengthening the foundation of upstream public health

Directly impacting the social determinants of health and health equity

Oregon Health Authority

Social Determinants of Health & Health Equity (SDOH&HE): Public input activities to date that informed policy strategies

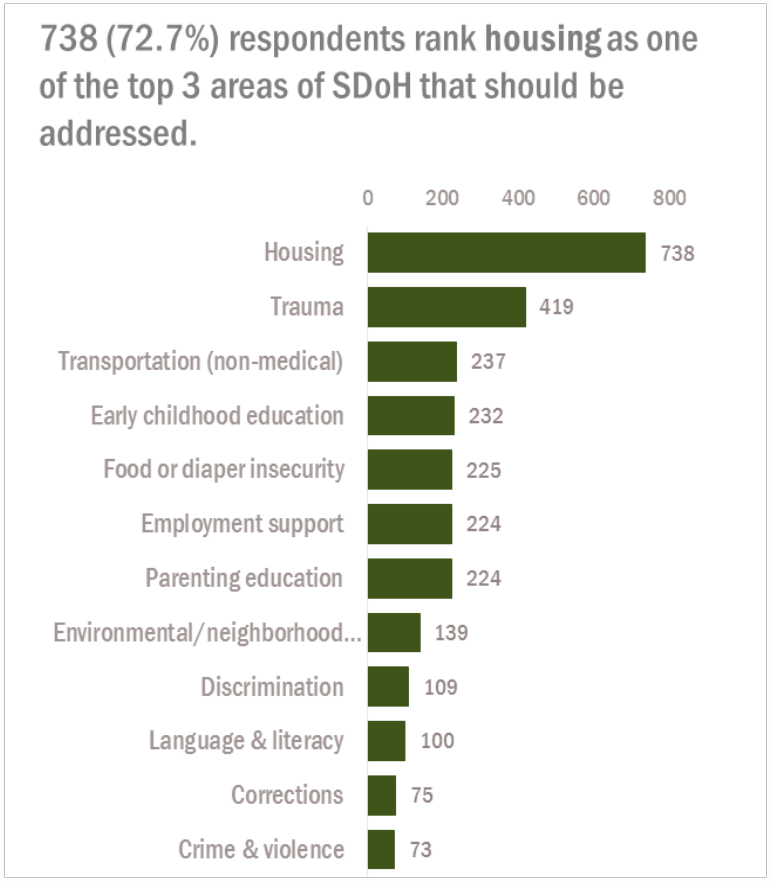
- Health Information Technology Advisory Group (HITAG)
- OHPB Health Equity Committee (HEC)
- CCO Community Advisory Council (CAC) Annual Event
- OHPB Public Health Advisory Board (PHAB)
- OHPB Health Information Technology Oversight Council (HITOC)
- Allies for a Healthier Oregon (AHO) SDOH forum
- Traditional Health Workers Commission
- Medicaid Advisory Committee (MAC)
- OHPB Healthcare Workforce Committee (HCWF)
- CCO CEO public meeting
- Oregon tribal webinar
- + survey and forums

SDOH&HE public input– Key themes

- SDOH&HE confirmed as a significant area in need of attention, support, partnership and spending
- Support for development of a standard definition of SDOH
- CCO SDOH&HE initiatives should be community-driven and $ should flow as much as possible to community partners doing the work
  - CAC has the potential to play a strong role
  - Important to consider the role of public health and maintain a focus on prevention efforts that promote population health
- Desire for culturally responsive care
  - Strong support for Traditional Health Workers, especially Community Health Workers
- Potential challenges with measurement of SDOH&HE need and impact of initiatives (e.g. data collection, HIT infrastructure)

Proposed statewide priority for spending: Housing services and supports

- Housing and related supports were cited as a strong need frequently across public forums, in committee meetings, and in the CCO 2.0 public survey.
- Opportunities exist for cross-agency partnership to leverage housing infrastructure investments with increased housing supportive services provided by CCOs.



Source: CCO 2.0 survey

Moving forward with SDOH & Health Equity in CCO 2.0: A case study

- OHA staff explored and vetted nine overall policy options with 25 strategies intended to improve SDOH&HE outcomes at the member, organizational, and community levels. For example:
  - Improve member health and reduce health care costs through addressing SDOH&HE factors like housing and food insecurity
  - Build CCO and community partner infrastructure to address SDOH&HE
  - Improve cultural responsiveness of CCOs and provider networks
  - Increase the use of traditional health workers to provide culturally and linguistically appropriate care and address SDOH&HE

- The following case study illustrates how SDOH&HE might show up in a clinical setting, and how the potential CCO 2.0 policy strategies can improve outcomes

Sarah's Story

- Sarah is an Oregon Health Plan (OHP) member, enrolled in a CCO.
- Sarah is a 35-year-old Hispanic woman in her 5th pregnancy.
- She lives in rural Oregon and works seasonally at a packing house.
- She is getting prenatal care at a local clinic.

Sarah's story today

- Sarah started prenatal care late at approximately 24 weeks gestation.
- The clinic doesn't know that Sarah is food insecure and is experiencing housing instability. The family lives with Sarah's sister temporarily, as they lost their housing a few months ago.
- Sarah was diagnosed with gestational diabetes and referred to a nutrition program that is not culturally appropriate, offering foods that are new to her.
- Sarah's husband has worked fewer hours to care for the children.
- Sarah needs dental care during her pregnancy, but access is limited in her rural community.

Sarah's outcomes today

- Sarah struggles to control her blood sugar and participate in the nutrition program, because the diet is unfamiliar and not culturally appropriate.
- Sarah's dental health gets worse during pregnancy.
- Sarah is diagnosed with pre-eclampsia in late pregnancy and must deliver her baby pre-term.
- Postpartum, her food insecurity and housing issues continue and worsen. She misses her 6-week follow up appointment due to her challenges at home. Sarah develops an infection related to her C-section wound and is readmitted to the hospital.

Sarah's story in 2025

Sarah meets a bicultural Community Health Worker (CHW) at a community event and starts prenatal care early.

Sarah's clinic screens for social determinants of health factors, which identifies she has housing instability, is food insecure, and has childcare challenges. A CHW refers her to a housing case manager at a local non-profit to get help finding affordable housing.

Sarah is diagnosed with gestational diabetes and referred to a culturally specific Veggie Rx program. She gets help to enroll in Supplemental Nutrition Assistance Program (SNAP) so she can participate in the Double Up Food Bucks program run by the local health department (a program that matches up to $10 spent on fruits and veggies at the new local farmers market). She can keep eating healthy foods and stretching her food dollars well past her pregnancy.

Sarah's husband can work full time, since the local Early Learning Hub helped Sarah connect with Head Start and after care program for her kids that includes transportation.

Sarah can get dental care from a local hygienist practicing teledentistry with a dentist in another community.

Sarah's outcomes in 2025

- Sarah keeps her blood sugar in check with help from the culturally specific Veggie Rx program which supports a diet rich in fruits and vegetables. She gets a dental cleaning during her pregnancy that helps prevent the onset of periodontal disease.
- Sarah's baby is born at term with minimal complications.
- Postpartum, Sarah's family continues to eat a diet rich in fruits and vegetables with help from the Double Up Food Bucks program, which helps her incision heal. The family moves into affordable, secure housing. Sarah is able to keep her follow up appointment and does not need to be readmitted to the hospital.

How did we get here?

- Underlying Sarah's successful pregnancy is a stronger infrastructure at the CCO, clinic, and community level to address the social determinants of health and health equity.
- Various changes in policy have led to community-level outcomes that support Sarah's care, such as:
  - Stronger community organization and public health programs supporting increased access to healthy food and stable housing, due to CCO spending.
  - The CCO's Community Advisory Council (CAC) is active, empowered, and in tune with the local community due to a diverse membership.
  - Shared community health assessments and plans have helped ensure resources are leveraged and common community priorities ensure maximum impact.

- CCO 2.0 policy options can help get us here.

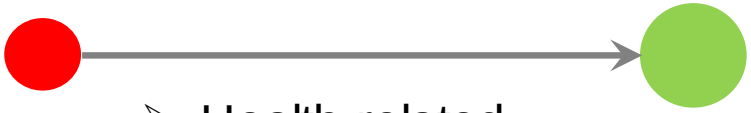
How can CCO 2.0 policies get us here?

- Spending requirement/seed money
- Definitions of SDOH&HE
- CHA & CHP collaboration and investment

CCO received **seed money** from OHA in 2020 to meet **ongoing SDOH spending required by HB 4018**. Used state **definition** of SDOH as guidance to invest in:

- SDOH screening and Electronic Health Record (EHR)-linked referral system
- Funding a housing case manager at a local non-profit, in line with statewide spending priority on housing
- Funding a local organization to establish a farmers market in a food desert, in line with **shared Community Health Assessment (CHA)/Community Health Improvement Plan (CHP) priority** to address food insecurity and obesity. Obesity is a **State Health Improvement Plan (SHIP) priority**. **Key SDOH partners, including THWs, involved in CHP development**

How can CCO 2.0 policies get us here?



- Health-related services
- CAC/CCO partnerships and meaningful engagement of diverse consumers
- CCO infrastructure for health equity support and coordination

CCO uses **health-related services** to fund:

- Veggie Rx for Sarah
- Double Up Food Bucks program at local public health department (**an initiative selected by CAC from the CHP priorities**)

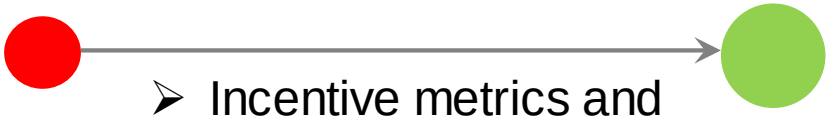
The CAC has **diverse representation and SDOH organization participation in line with CHP priorities**. **Two CAC members, including an OHP member**, sit on the CCO's board to help drive CCO decisions.

The CCO has accountability and dedicated resources for health equity activities, including a **health equity plan** that includes cultural responsiveness TA and education for provider network.

How can CCO 2.0 policies get us here?

- Integration/utilization of Traditional Health Workers (THW)

CCO established a **sustainable payment system** and hired/identified a **THW liaison. The liaison** worked closely with the THW Commission to establish a **comprehensive THW utilization plan,** including **best practices** and contracting with a local organization that employs THWs, including the community health worker who connected with Sarah.



- Incentive metrics and resourcing of community partners

CCO has met the **SDOH metric** (e.g. kindergarten readiness) for the past two years. Part of the CCOs **incentive pool funding** goes to the local Early Learning Hub to support its programs, which help the CCO reach its metric. The ELH is able to expand its work to connect with local clinics for referrals.

- Telehealth reimbursement

As required, the CCO reimburses for telehealth and teledentistry services when medically necessary.

Summary: Social Determinants of Health and Health Equity (SDOH&HE) Policy Options

Questions	Policy Options
How can OHA encourage CCOs to spend more in social determinants of health & equity work, and hold CCOs accountable for their spending?	Requirements for strategic spending by CCOs on social determinants of health and health equity/disparities
	Health-related services (HRS) as a mechanism to invest in the social determinants of health and equity in communities.
	SDOH and health equity incentive metrics
	Common definitions of social determinants of health, health equity, and related concepts
How do we strengthen CCO partnerships and ensure meaningful engagement to support social determinants of health & equity work?	Community Advisory Council (CAC)/CCO partnerships and meaningful engagement of diverse consumers
	Community Health Assessment (CHA) and Community Health Improvement Plan (CHP) collaboration and investment
How do we better ensure provider cultural responsiveness, language accessibility, a diversified workforce, and access to critical services across the state within a CCO and its provider network that reflects the population served by the CCO?	CCO internal infrastructure and investment to coordinate and support CCO equity activities
	Strengthening requirements for Traditional Health Worker integration and utilization
	Standardization of telehealth reimbursement requirements
What changes can we make to improve our understanding of social determinants of health & equity initiatives and disparities?	SDOH&HE Data and Accountability – To be determined during Phases 2 and 3 of Policy Development Timeline

Questions

- What reactions do you have to the overall package of policies?
- Are there policy areas that you would like to prioritize at this time?

Thank you!

CCO 2.0: Sustainable Health Care Spending

OHPB meeting

June 5, 2018

HEALTH POLICY
Health Policy and Analytics

Presentation Overview

- Policy Development Process
  - Internal policy development
  - Stakeholder engagement
  - Guiding questions & policy goals
- CCO 2.0 Sustainable Health Care Spending Policy Options
  - Categories of proposed options
  - Policy options under consideration
- Feedback from Roundtables and Stakeholder Outreach

Oregon Health Authority

Policy Development

- Cross division topic area team
  - Finance: Laura Robison, Chelsea Guest, Kate Koustareva, Dan Roe, Clair Clark, Megan Auclair
  - HPA: Tim Sweeney, Zachary Goldman, Jon Collins, Jason Gingerich
  - HSD: Jean Hutchinson, David Simnitt (targeted conversations)
- External stakeholder engagement
  - Expert roundtable convened to vet options – includes CCOs, consumer reps, clinicians, academic experts
  - Feedback from other groups including: PHAB, Health Care Workforce Committee, Medicaid Advisory Committee, CCO-CEO meetings, individual CCOs and others

Questions to Guide Policy Development

- Is 3.4% still the proper growth target for the entire CCO 2.0 contract period?
- What cost drivers threaten achievement of sustainable growth rate (3.4%) in future years?
- What cost drivers warrant additional analysis to help OHA and CCO partners continue to meet growth targets?
- What strategies could increase CCO financial accountability while preserving flexibility to operate within global budget?

Overarching Policy Goals

- Ensuring OHA & CCOs have the data and tools necessary to analyze, incentivize, and reward efficiency and value and replicate success
- Aligning financial framework with broader policy goals that reward outcomes, provide accountability, and reduce cost growth to meet sustainable spending targets
- Ensuring financial sustainability of the CCO program

CCO 2.0 POLICY OPTIONS & DISCUSSION

Continue to Achieve Cost Containment and Sustainable Health Care Spending Growth in the CCO Model

Oregon Health Authority

Financial Framework Policy Categories

The following are the financial categories OHA is currently exploring based on overarching goals:

1. **Spending targets and cost containment**
2. **Promoting efficiency and high value care**
3. **Quality pool payments and structure**
4. **Mitigating financial risks & outlier costs**
5. **Financial reporting and reserves**
6. **Ensuring accurate and sufficient encounter data**

Spending Targets and Cost Containment

Potential Strategies

Policy Goal: Maintain an aggressive spending target in CCO contracts and promote cost containment by sharing savings with CCOs

1. Ongoing evaluation of sustainable spending targets based on national trends and emerging data
2. Shared-savings arrangements for achievement of lower-than-targeted spending growth
3. Include sustainable growth target as a contract requirement to increase CCO accountability

Promoting Efficiency & High Value Care

Potential Strategies

Policy Goal: Incentivize CCO efficiency and promote the use of health care services with highest clinical value

1. Evaluate efficiency and total costs of care to establish variable profit margins based on CCO performance
2. Incentivize health care services with highest clinical value by rewarding their use in rate setting
3. Increase the portion of payments to hospitals that are based on quality and value

Quality Pool Payments and Structure

Potential Strategies

Policy Goal: Incentivize CCOs to invest quality pool funds on programs, providers and partners that improve quality and enable CCOs to achieve selected metrics, while ensuring accountability and reducing cost growth

1 Adjust the operation of the CCO Quality Pool to allow consideration of expenditures in CCO rate development

- Align incentives for CCOs, providers, and communities to achieve quality metrics
- Create consistent reporting of all CCO expenses related to medical costs, incentive arrangements, and other payments regardless of funding source

Mitigating Financial Risks & Outlier Costs

Potential Strategies

Policy Goal: Spread and manage risk related to low frequency, high-cost conditions and treatments

1. OHA administered reinsurance pool to spread the impact of low frequency, high-cost conditions across entire program
2. Expand current risk corridor programs
3. Address increasing pharmacy costs and the impact of high-cost and new medications

Financial Reporting and Reserves

Potential Strategies

Policy Goal: Enhance alignment of CCOs risk and financial requirements to ensure CCO solvency, accountability, and consistency of data

1 Enhance current reporting by:

A. Building on existing templates (Exhibit L) and reevaluate reserve requirements and calculations to better account for risks CCOs bear, OR

B. Move to NAIC reporting standards used by commercial insurers and a Risk Based Capital approach to evaluate solvency requirements

2 Create a statewide reserve pool in addition to CCO-specific requirements in the event of an insolvency

Accurate & Sufficient Encounter Data

Potential Strategies

Policy Goal: Consistent and accurate reporting of services provided and their associated costs

1 Institute a validation study that samples CCO encounter data and reviews against provider charts for accuracy (AZ Model) with financial implications

2 Require complete encounter data with contract amounts and additional detail for value-based payment arrangements

HIGHLIGHTS OF PUBLIC FEEDBACK ON POLICY OPTIONS

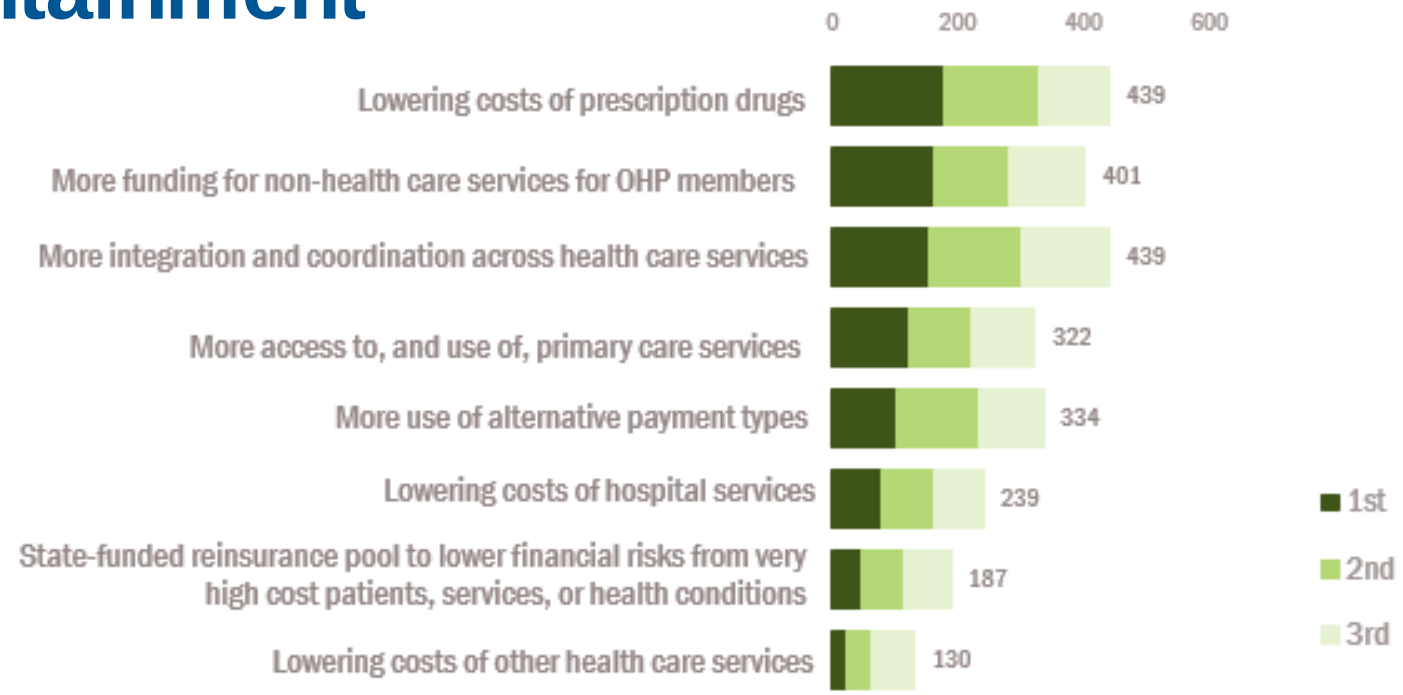
Oregon Health Authority

Major themes of roundtable feedback

- CCOs (and others) value flexibility & local control
  - View current program as successful; new policies should leverage existing framework and not disrupt current programs / structure
    - More substantial changes need to clarify problem(s) in need of solution
- Broad concern about whether new initiatives would come with funding to enable new CCO programs / investments
- Noted potential timing concerns and potential for additional lead time prior to implementation (i.e., 2020 may be too soon)
- External stakeholder aware of challenges OHA & CCOs face controlling costs
- Great interest in the "how would it work" details
  - CCO / local difference influence view of the details

Cost Containment

Which of the following areas are the most important ways for the state of Oregon to control health care costs and keep spending within targets set by the Legislature?

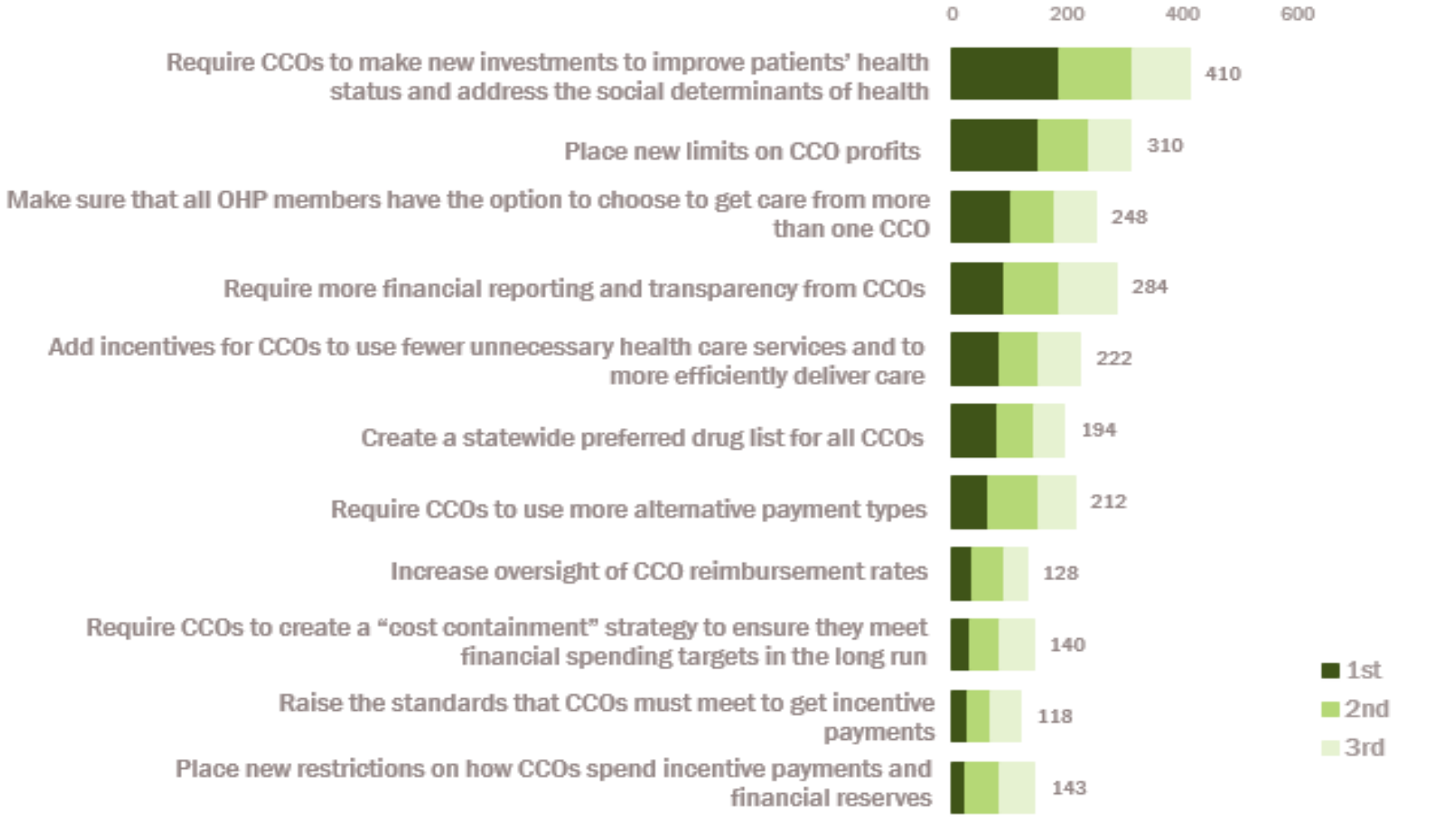


Themes:

Comments centered on the role of the global budget, challenges related to transparency of funding, ideas about how to lower costs, identifying cost drivers; reimbursement rates of providers.

Cost Containment (Continued)

What should the state require CCOs to do to reduce the costs of delivering health care services to OHP members?



Broad questions to drive conversation

- What reactions do you have to the overall package of policies?
- Are there policy areas that you would like to prioritize at this time?

CCO 2.0: Value-based Payments

OHPB meeting

June 5, 2018

Oregon Health Authority

HEALTH POLICY
Health Policy and Analytics

Value-based Payment in CCO 2.0:
Policy development topic area team

Subject matter lead	Chris DeMars, Transformation Center
Project management and policy lead staff	Lisa Krois, Transformation Center Zachary Goldman, Office of Health Analytics Summer Boslaugh, Transformation Center
OHPB policy liaison	Jeff Scroggin, Office of Health Policy
Additional subject area experts	Jon Collins, Office of Health Analytics Jamal Furqan, Health Systems Division

Oregon Health Authority

Overview

- Value-based payment (VBP) background
- Potential VBP Policy Options
- Feedback and questions

Driving forces for increased VBPs

The goal of increased use of VBPs is to incentivize delivery system reform that focuses on ***value*** instead of volume of care delivered, ***rewarding*** providers for a combination of ***high-quality care, positive member health outcomes*** and ***cost savings.***

- Strategies to increase value-based payments and paying for performance is one of **Governor Brown's** four priority areas for recommendations from OHPB

- **Oregon's 1115 Waiver:** Requires OHA to develop a plan ("VBP Roadmap") describing how the State, CCOs and network providers will achieve a set target of VBP by June 30, 2022

- **2018 CCO contract:** Requires CCOs to engage in collaborative efforts with OHA to develop a VBP Roadmap

Value-based payment and the triple aim

- Volume-driven care
- Focused on acute singular event
- Payer and provider incentives not aligned

- Value (not volume) of care
- Prevention and care coordination for improved quality and health outcomes
- Aligned incentives between payers and providers

Joel's story

Joel has diabetes and visits his primary care provider because he isn't feeling well.

FFS Payment System

- Primary care provider senses Joel is depressed; recommends behavioral health visit; moves quickly on to next patient.
- Joel receives a phone number for his "referral"; is told to make own appointment.
- Joel's depression gets worse; he stops his insulin and loses motivation to do small tasks, including setting up the appointment.
- Joel's depression causes him to miss a week at work without calling in; he loses his job.
- Joel ends up in ER, suicidal with early signs of kidney damage.

VBP System

- Primary care team huddles before Joel's appointment; he's due for depression/substance abuse screening.
- Joel fills out screening tool before visit; provider knows he's depressed when visit starts.
- Provider makes a warm hand-off for Joel to the clinic's on-site behavioral health provider, who the clinic brought on with its prospective, lump-sum payment that gives it flexibility to support "whole person" health needs of the clinic population.
- Joel receives support to begin to manage his depression; continues to manage his diabetes; and goes to work the next day.

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Public engagement to date

- CCO 2.0 survey and public forums (Portland, Hood River, Woodburn and Medford)
- CCO Value-based Payment Work Group (*per waiver requirement*)
  - Three facilitated meetings with all CCOs represented; final meeting public
- VBP provider survey (*per waiver requirement*)
- Presentations at:
  - Quality and Health Outcomes Committee
  - Primary Care Payment Reform Collaborative
  - Medicaid Advisory Committee
  - Healthcare Workforce Committee
  - Health Information Technology Oversight Committee *(upcoming, June)*
- Written comments submitted by external partners (*collected to-date*):
  - Oregon Academy of Family Physicians, Oregon Medical Association, CareOregon, Oregon Primary Care Association, OCHIN, Coalition of Local Health Officials, Trillium Community Health Plan

Public engagement – key themes

- Written comments by stakeholders
  - Largely supportive of increased use of VBPs; requests for meaningful incentives and metric alignment for providers; concerns around data-sharing; consideration of VBPs within rate-setting.
- CCO 2.0 VBP Survey Themes
  - Comments mixed between VBP being the right direction and VBP challenges in implementation and practice.
- VBP Provider Survey Themes
  - Experience with VBPs; blended model of FFS and capitation has been effective to shift from FFS to VBP; concerns regarding meaningful incentives and metric alignment, sufficient/timely data, and behavioral health integration.

OHA value-based payment opportunities

Enhancement of VBP in the Oregon Health Plan

- Oregon Health Authority payments to CCOs
- **CCO payments to their providers**

Focus for CCO 2.0

Opportunities for VBP alignment

- Within OHA:
  - Public Employees' Benefit Board
  - Oregon Educators Benefit Board
- Between OHA and other payers
  - Comprehensive Primary Care Plus
  - Primary Care Payment Reform Collaborative

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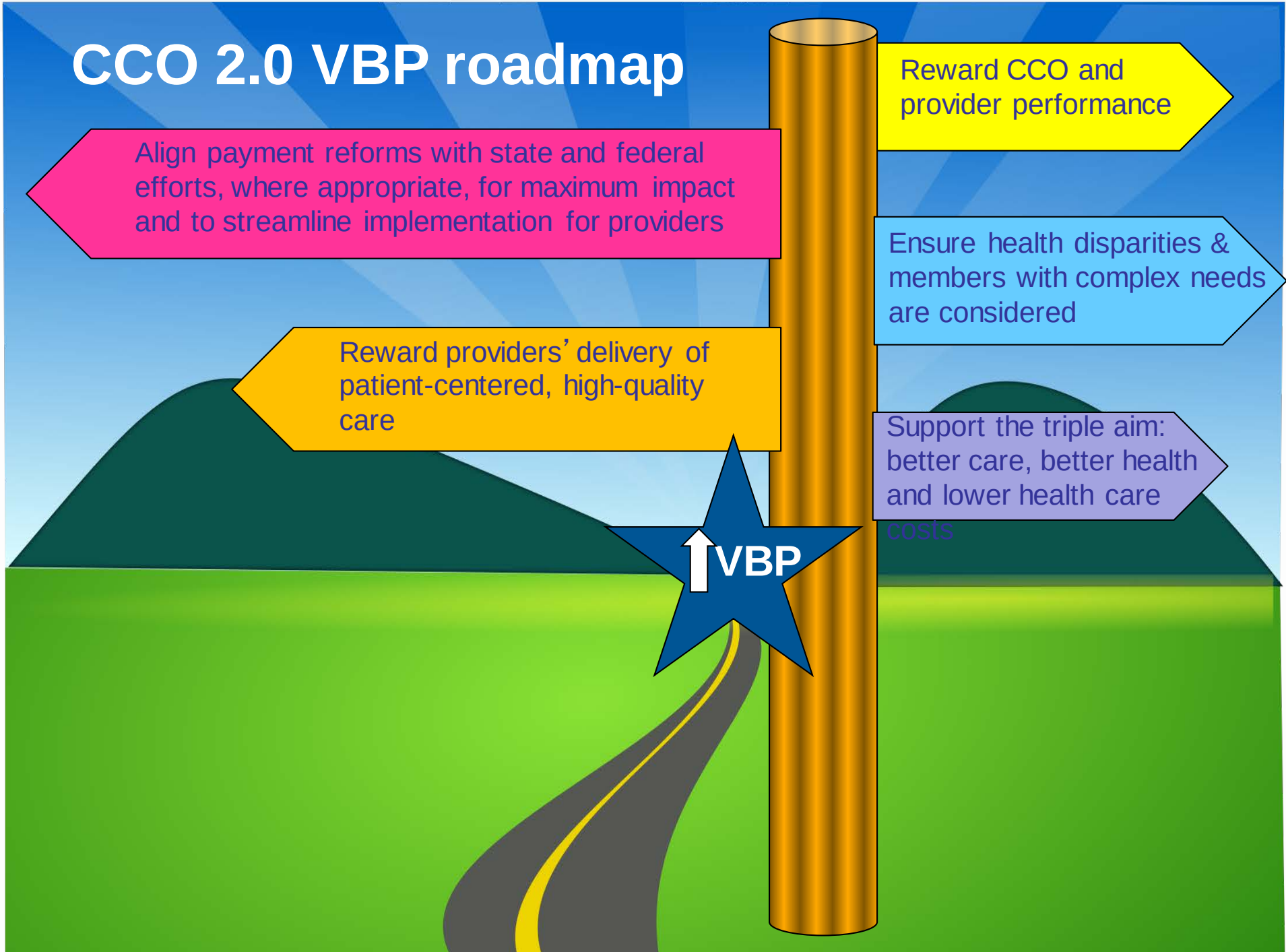
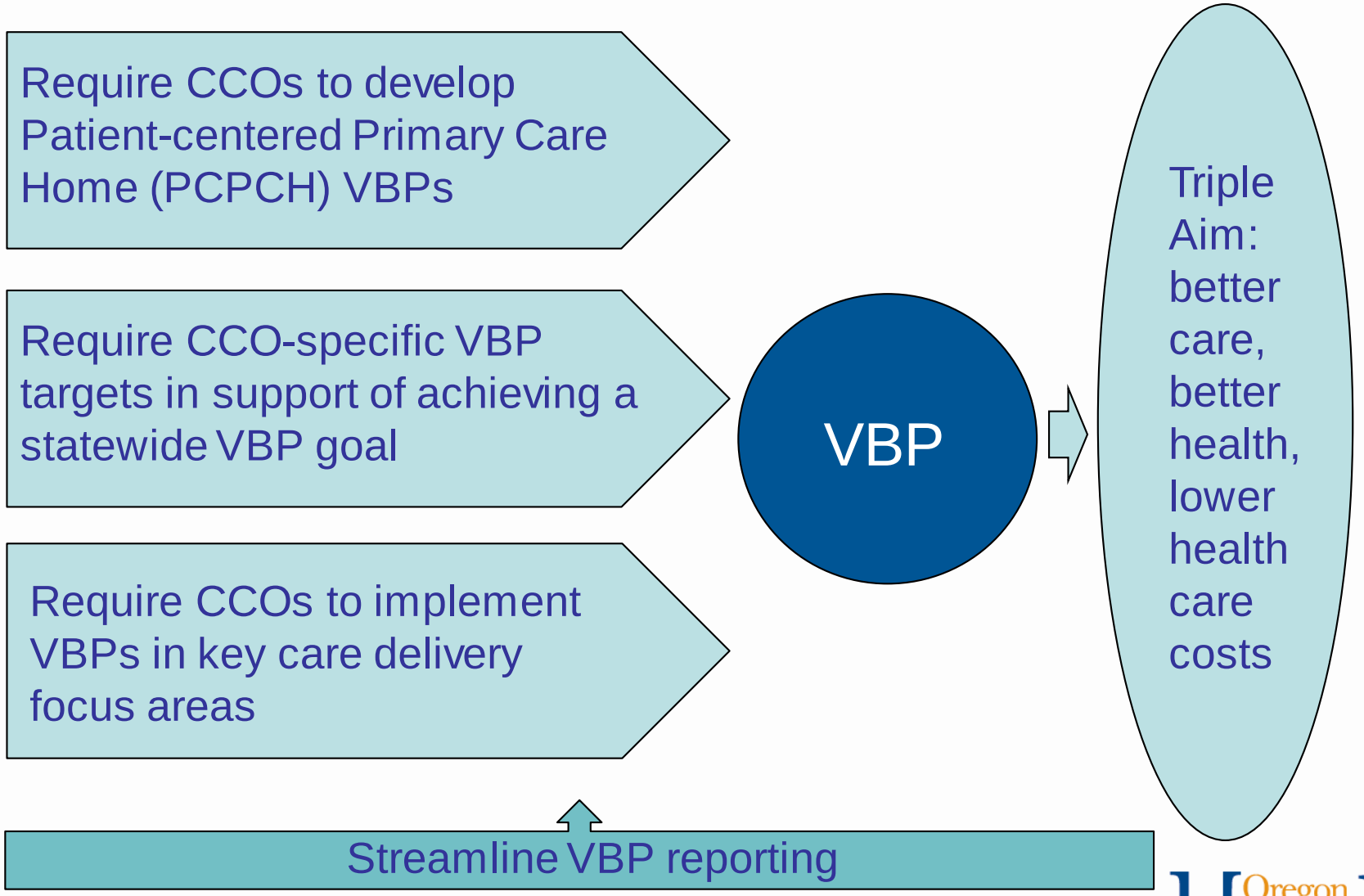
CCO 2.0 VBP roadmap



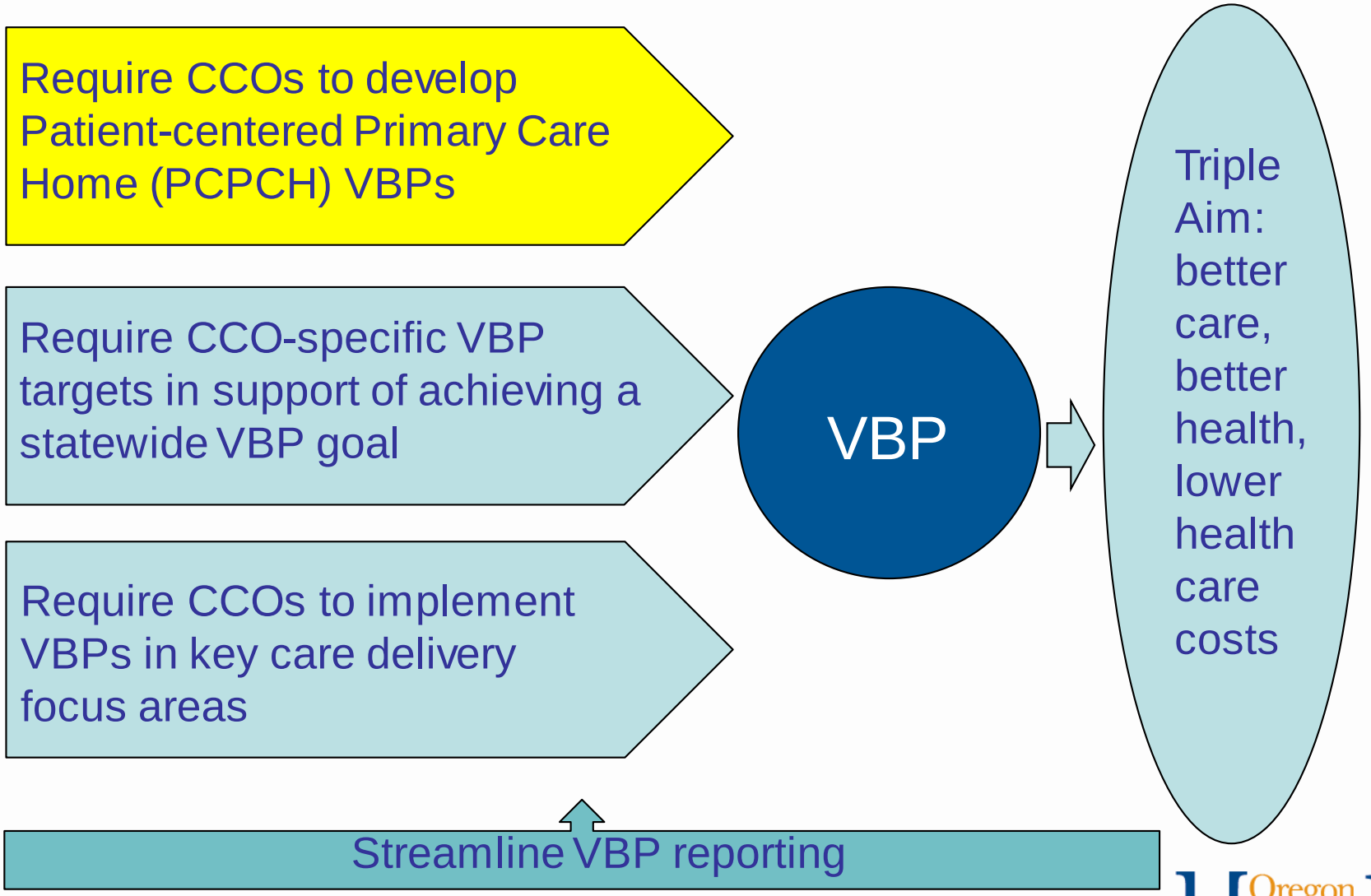
VBP lessons learned in the first 5 years

- The use of VBP varies by CCO
- CCOs use payment models beyond FFS, but have less experience linking payment to quality
- CCO differences in geography, plan size and provider market power means a "one-size-fits-all" VBP approach will not work
- Current reporting does not adequately capture CCO VBP activities

CCO 2.0: VBP potential policy options



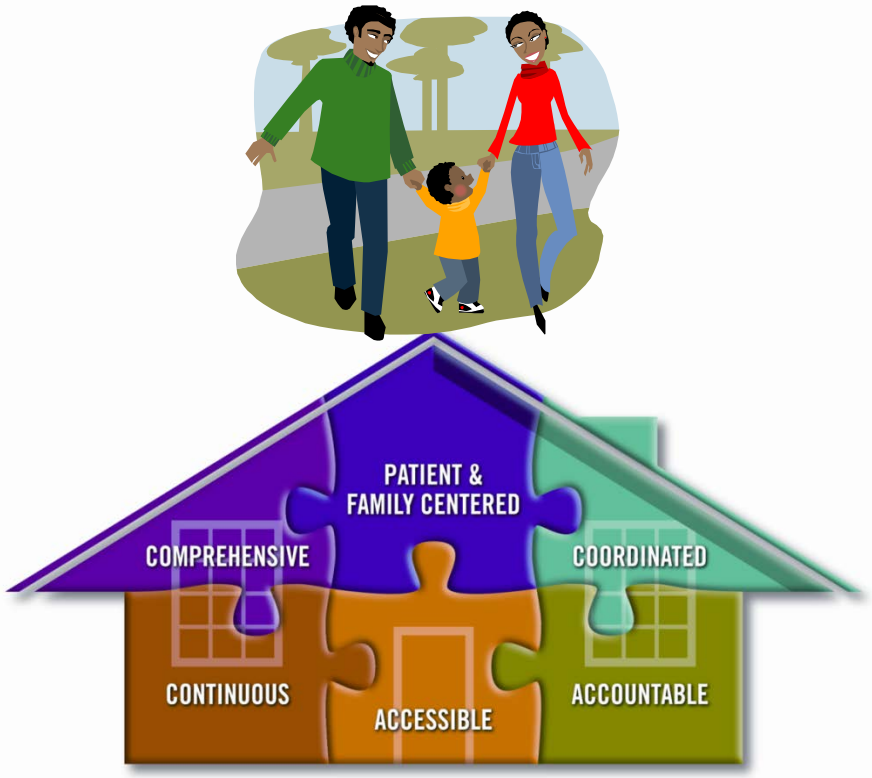
CCO 2.0: VBP potential policy options



Value-based payments to PCPCHs

Require infrastructure payments (i.e., payments based on PCPCH tier level):

- Provide financial support for PCPCHs to implement and sustain a robust PCPCH model of care
- Support staff and activities that are not reimbursed through FFS



PCPCH program evaluation* findings:

- PCPCH Program encouraged clinics to embrace team-based care.
- Every $1 increase in primary care expenditures related to the PCPCH Program led to $13 average health care system savings.

*Portland State University, 2016

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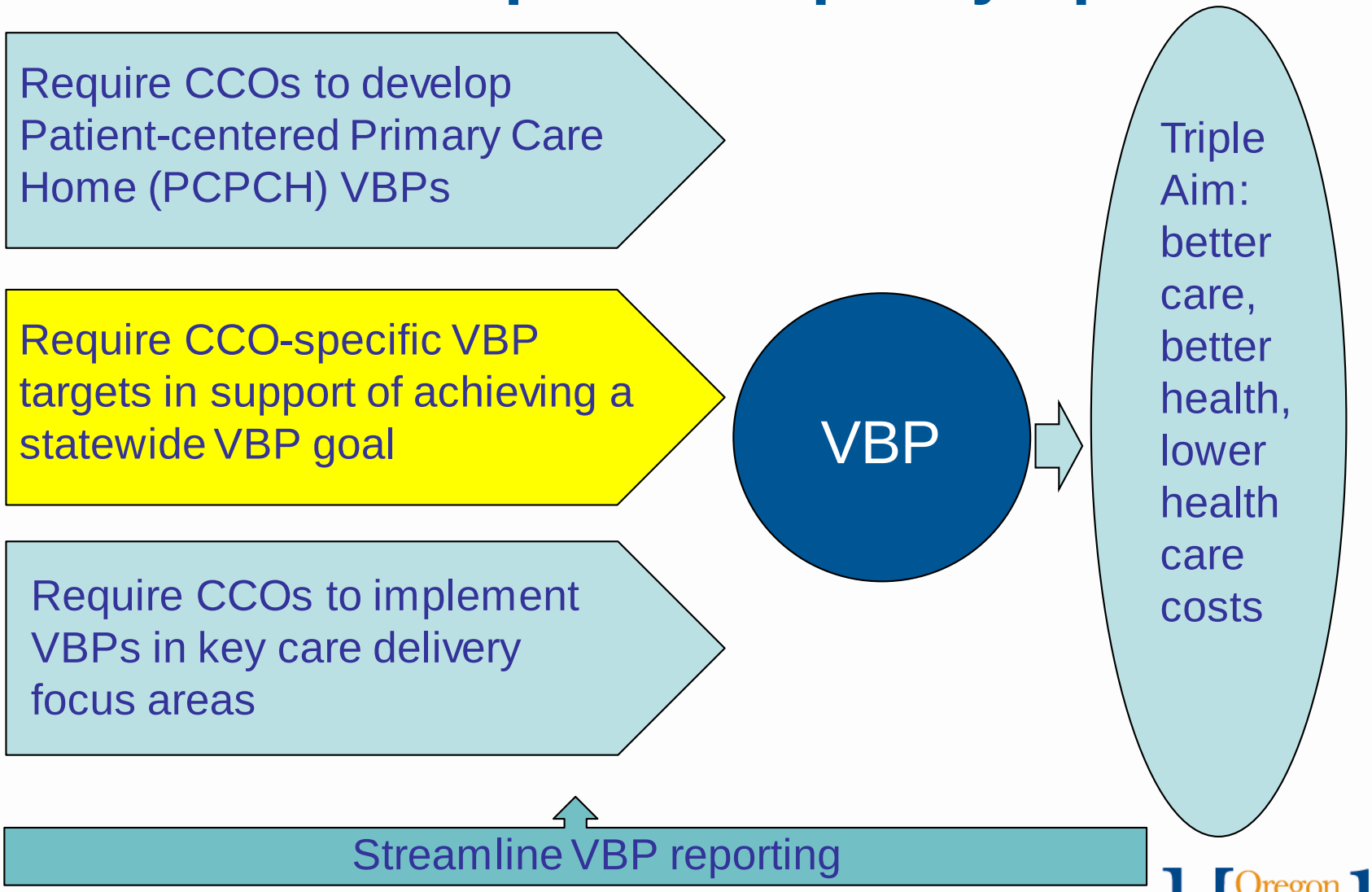
CCO 2.0: VBP potential policy options

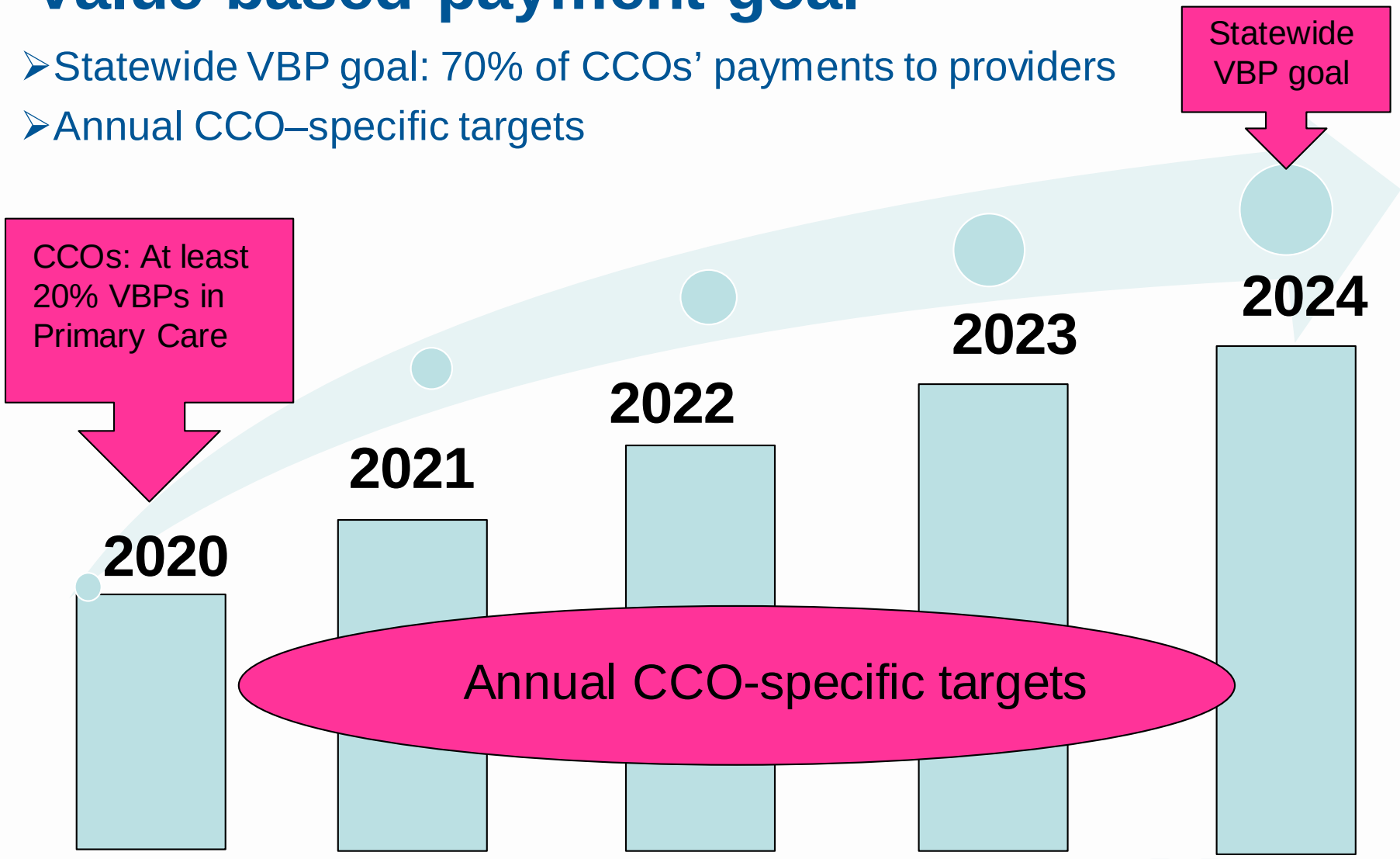


Health Care Payment Learning and Action Network (LAN) VBP Framework

Example payment model	Explanation
Pay-for-performance	-Incentives/disincentives for providers that achieve/fail to achieve quality improvement targets -Example: the CCO Quality Pool Program acts as a pay-for-performance VBP
VBP with shared savings and downside risk	-Providers are eligible to share in savings, but are also at risk for financial penalties based on performance against cost budgets (and at times for performance on quality measures). -Example: Bundled payments for maternity care
Condition-specific population-based payment	-Providers are prospectively paid a lump sum that covers all care they deliver for a specific condition, -Example: Lump-sum payments to manage chronic conditions such as diabetes

Value-based payment goal

- Statewide VBP goal: 70% of CCOs' payments to providers
- Annual CCO–specific targets



- All VBP targets must be at LAN Category 2C or higher
- Category 2C is similar to the CCO Incentive Metrics Program

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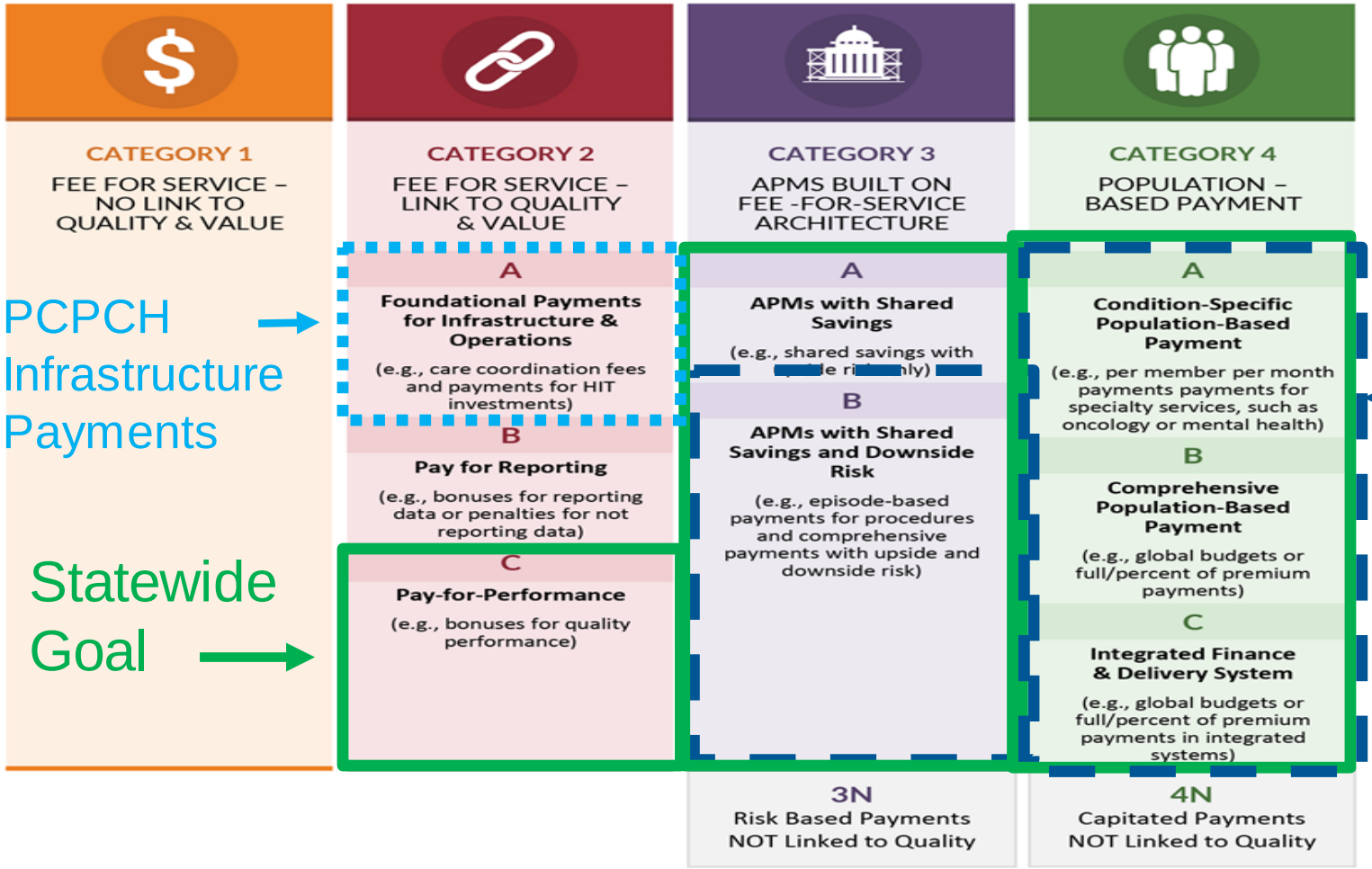
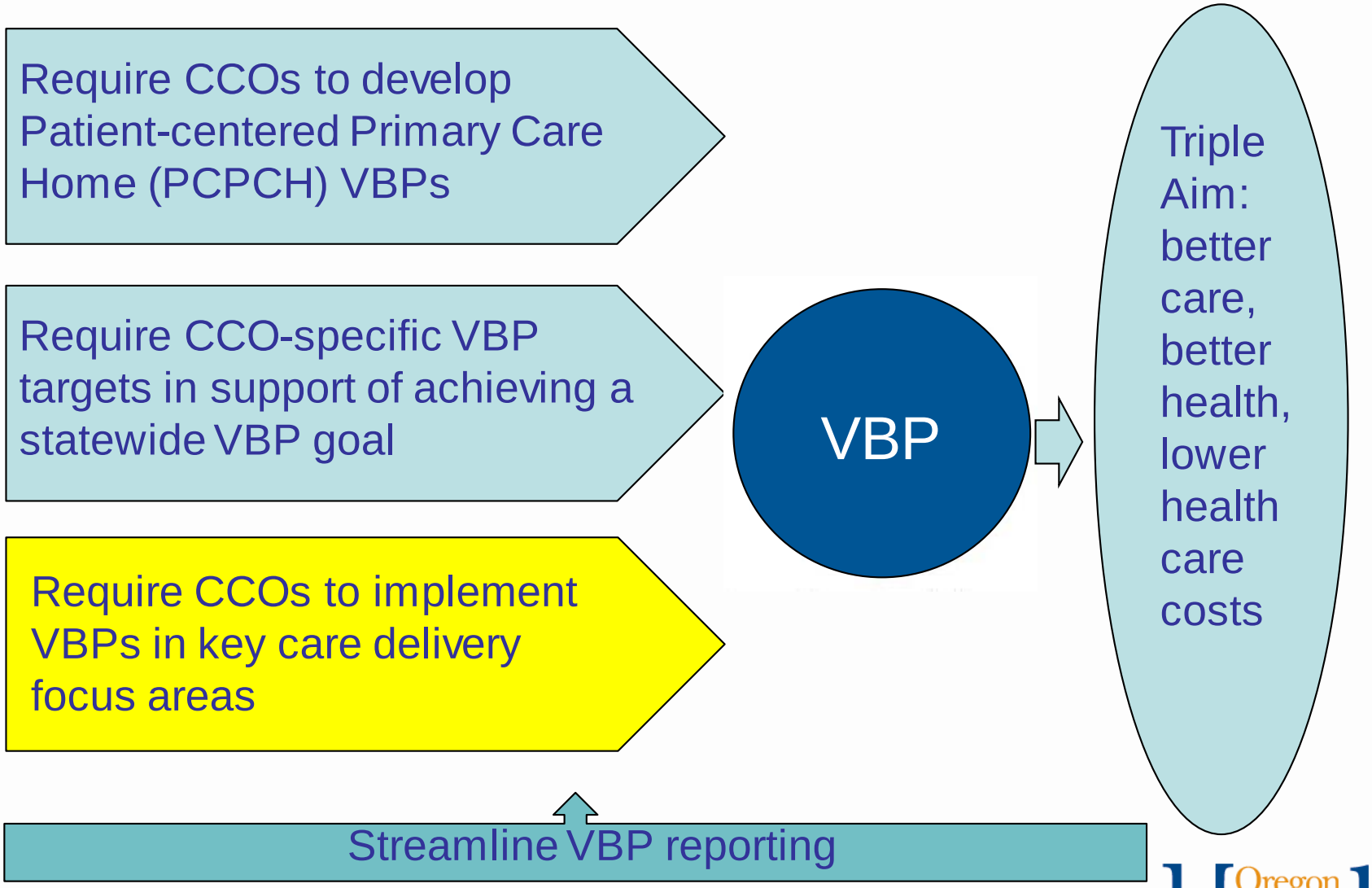
LAN VBP Framework: Proposed VBP Goals



State VBP targets using LAN framework

State	State Requirement: LAN Category	State Requirement: VBP Percentage
AZ	2c or higher	70% of payments by 2021
CA	2, 3 & 4 in 2018; 3 & 4 in out years	60% of enrollees by 2020 (for enrollees within designated public hospital system)
NY	3a or higher	80% of payments by 2020
SC	2c or higher	20% of payments by CY 2017
VA	"emphasis on 3 & 4"	
WA	2c or higher	90% of payments by 2021; 50% in Category 3

CCO 2.0: VBP potential policy options



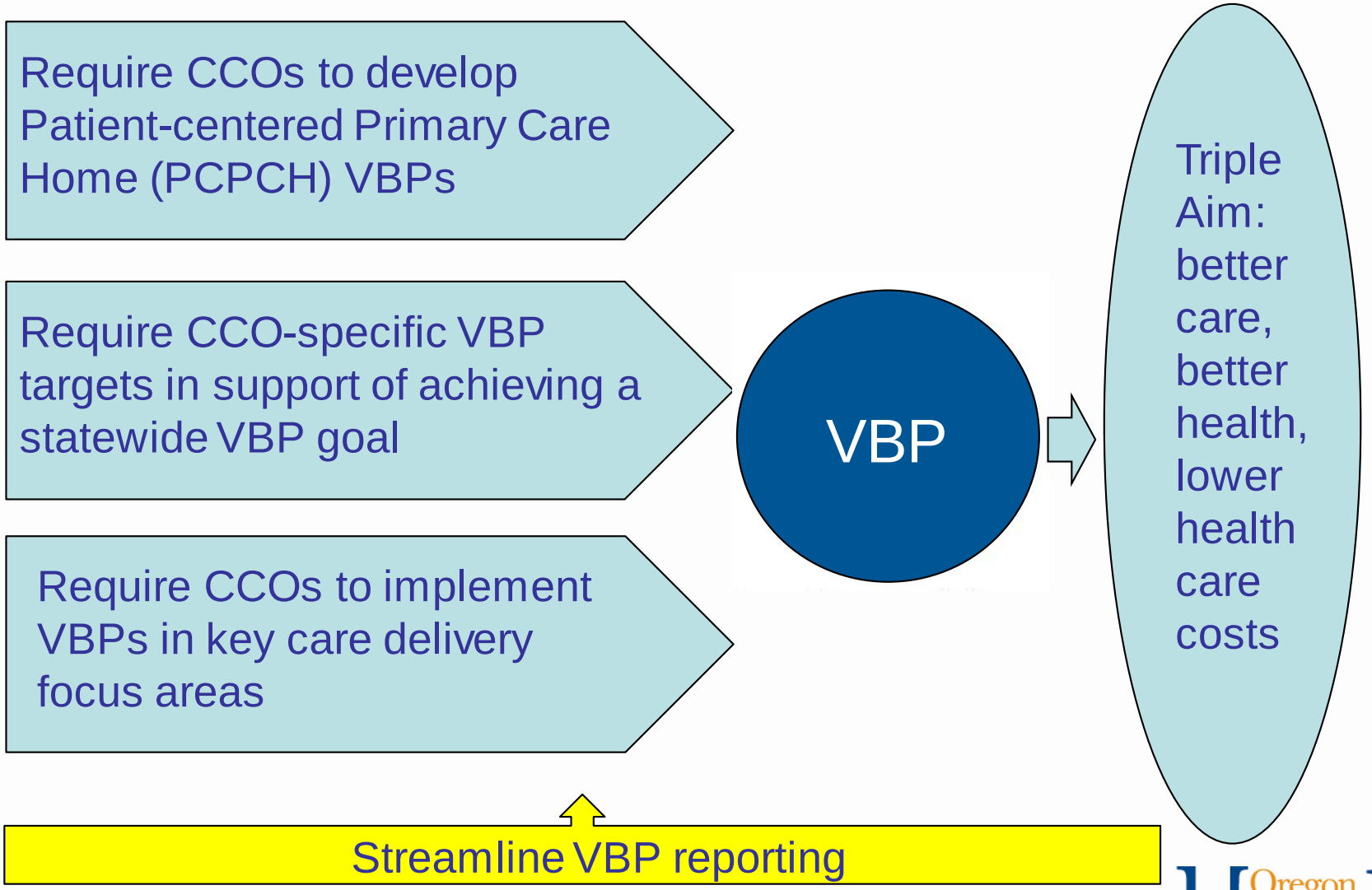
VBPs in key focus areas

CCOs required to implement a VBP focused on each of these key care delivery focus areas:

- Flexibility of VBP models, design and size (i.e., no spend or population size requirement)
- VBP models may include more than one care delivery focus area
- Uses VBP as a lever to advance OHA goals
- May lead to more robust VBP requirements in one/more areas in later years

VBP care delivery focus area	Select criteria driving inclusion of focus area
Primary care	Foundational to CCO model; alignment with other statewide VBP activities
Behavioral health integration	CCO 2.0 priority; VBP can promote integration
Oral health integration	Foundational to CCO model; VBP can promote integration
Children's health care	Governor's priority; widespread public support
Maternity care	Governor's priority; major area of spending
Hospitals	High-cost; minimal CCO VBP experience
Specialty care	High-cost; minimal CCO VBP experience

CCO 2.0: VBP potential policy options



Value-based payment reporting

- Require CCOs to demonstrate necessary information technology (IT) infrastructure for VBP reporting
- Streamline reporting by using All Payer All Claims (APAC) database for VBP reporting
- Collect supplemental data and/or interviews

Questions

- What reactions do you have to the overall package of policies?
- Are there policy areas that you would like to prioritize at this time?

Thank you!

CCO 2.0 Policy Options Debrief

General thoughts and reactions

- Are there any clarifying process questions?
- Anything particularly compelling?
- Any high-level concerns?
- Have you heard any community feedback?
- Anything from stakeholder and partner input/comments that you'd like to highlight?

Next steps

- Policy Development Phase 2
  - **Feasibility and Impact analysis**
  - Additional analysis, refinement, prioritization
  - More public input

- Greater understanding of issues like…
  - How would this be implemented?
  - What are the consequences (intended or unintended)?
  - Which of these should be prioritized?
  - How could these be prioritized?
  - What does the timeline look like for implementation?
  - Who else should be involved in this work or decision?

CCO 2.0 Road Show

Date	Time	City
18-Jun	6:30 - 8	Hood River
19-Jun	12 - 1:30	Pendleton or Hermiston
19-Jun	6:30 - 8	Ontario
20-Jun	12-1:30	Bend
21-Jun	6:30-8	Portland
26-Jun	12:30 - 2	Corvallis
	6:30-8	Springfield
27-Jun	11 - 12:30	Astoria
	7 - 8:30	Coos Bay
28-Jun	12:30-2	Klamath Falls

- + 1:1 tribal consultations if requested
- + online component (survey)
- + continued OHP member engagement

Phase 2 Timeline

- 6/6 – 7/2 Feasibility & impact analysis (F&I)
- 6/18-6/28 CCO 2.0 road show
- 7/10 July OHPB meeting
  - Review and address F&I
  - Summary of road show
  - **Prioritize policy options**
- 7/11-8/2 Writing of draft report
- 8/7 August OHPB meeting (review draft)
- 9/11 Sept OHPB meeting (final review)
- 10/1 Procurement drafting begins

Feasibility & Impact Analysis

Expectation for July meeting:

- OHPB members review/discuss F&I analysis and feedback from road show

- Make decisions about which policy options are prioritized moving forward

- OHA staff will then draft a report for review in Aug

Feasibility & Impact Analysis

Work across the topic areas

Step 1: deeper understanding of policy options

- Timeline for implementation
- Dependencies (e.g. legislation, federal approval)
- Brand new or variation of existing requirement
- Process-focused or outcome based

Feasibility & Impact Analysis

Step 2: information needed to prioritize

- Implementation challenges (e.g. cost, staff resources)
- Impact on Triple Aim and Equity
- Populations affected
- Known support/opposition

For more information on CCO 2.0 visit:
www.health.oregon.gov

Questions, comments, or recommendations?
Email CCO2.0@state.or.us

Thank you!

Oregon Health Authority

Health Plan Quality Metrics Committee

Progress Report to the Oregon Health Policy Board

Kristen Dillon, M.D., Committee Chair
Shaun Parkman, Committee Vice-Chair

June 5, 2018

Overview

- Committee Scope and Charge (brief review)
- Progress to Date
- What's Next?
- Challenges
- Request for Guidance

Committee Scope & Charge

Senate Bill 440 (2015) established the Health Plan Quality Metrics Committee (HPQMC) as the single body to align health outcome and quality measures used in the state, defining two specific functions of the committee:

1. To identify health outcome and quality measures that may be applied to
   - Coordinated care organizations for Medicaid
   - Health benefit plans sold or offered by:
     - The health insurance exchange
     - The Oregon Educators Benefit Board (OEBB)
     - The Public Employees' Benefit Board (PEBB)

2. To evaluate on a regular and ongoing basis the health outcome and quality measures adopted

Committee Scope & Charge

- HPQMC determines the quality and outcome measures state health care programs may use in their contracts with health plans

- HPQMC doesn’t overrule other quality and outcome reporting that health plans and providers may be required to do, such as
  - Federally mandated reporting
  - Reporting required under payment incentive programs (i.e., CPC+, MIPS)
  - Necessary reporting under accreditation programs
  - Reporting requested by other non-state employers and benefit plan sponsors

Progress to Date

- HPQMC has had monthly meetings since April 2017 and has reviewed 117 quality measures, focusing on measures consistent with criteria established in SB 440 as well as additional criteria articulated by the committee

- The committee has established an initial aligned measures menu for 2019 state contracting, which includes 51 quality measures across six domains
  - Prevention/Early Detection
  - Chronic Disease and Special Health Needs
  - Acute, Episodic and Procedural Care
  - System Integration and Transformation
  - Patient Access and Experience
  - Cost/Efficiency

Progress to Date

This chart summarizes the distribution of quality measures in the aligned measures menu across areas of care.

Existing measures largely focus on prevention and early detection.

Robust measures in the bottom four categories are scarce and often not useful to measure care provided to the members of a specific health plan.

Domain	Sub-Domain	Number of Menu Measures	Number of Measure Concepts for Further Committee Work
Prevention/ Early Detection	Physical Health Conditions	16	6
	Mental Health Conditions	1	0
	SUD Conditions	4	0
	Oral Health Conditions	3	2
	All Conditions	1	0
Chronic Disease and Special Health Needs	Physical Health Conditions	6	1
	Mental Health Conditions	4	3
	SUD Conditions	2	0
	All Conditions	2	1
Acute, Episodic and Procedural Care		5	5
System Integration and Transformation		2	2
Patient Access and Experience		3	0
Cost/Efficiency		2	0
Total		51	20

Progress to Date

The committee also identified:

- Three additional quality measures that are not yet ready for widespread reporting but will be included in the aligned measures menu within the next two years, coupled with sun-setting of related measures
- Twenty measure topics that involve important aspects of health where the committee has yet to identify existing meaningful measures
- Upcoming committee efforts will include work to seek or develop meaningful outcome-focused measures to address these measurement topics

Progress to Date

The committee recognizes gaps exist in the initial measures menu and believes longer term efforts to refine the measures menu should address these gaps.

- Health equity, heath care equity and reducing disparities
- Access to telehealth and other alternative to face-to-face visits
- Obesity and upstream factors and influences
- Behavioral Health
- System Transformation
- Children and Youth with Special Health Needs

What's Next?

- Create work plan for the next 1-2 years
- Move toward transformative measures – develop new measures and data sources
- Address need for subject matter expertise in areas of health care that don't have extensive quality measurement history (for example, health care equity, telehealth, oral health)
- Participate in formation of Equity Measures Subcommittee
  - Identify best methods and approaches for health equity and disparities measurement
  - Make recommendations about measures for adoption to HPQMC and the Metrics & Scoring committee
- Observe which measures from the initial menu are adopted and remain in dialog with stakeholders to continue to refine the measures

What's Next?

Two additional workgroups are currently underway and will provide recommendations

- Health Aspects of Kindergarten Readiness : a technical workgroup convened by the Children's Institute with support from OHA will recommend measures of the health sector's role in kindergarten readiness and identify opportunities for future measure development and data sharing

- Obesity Measures: OHA convened workgroup will define and test evidence-based measures related to obesity and develop measure recommendations

Challenges – Measure Criteria

SB 440 directs the committee to prioritize measures that are already in use, rely on existing data, and are not subject to random variation based denominator size.

- Measures meeting this criteria typically focus on clinical processes and may not drive health outcomes or system transformation
- Existing measures do not sufficiently address areas such as health equity, social determinants of health, and outcomes
- This does not need to be addressed through legislation but does explain the imbalances and gaps in the current measures menu

Challenges – Level of Measurement

SB 440 charges the committee with selecting measures tracked at the health plan level.

- Many measures match poorly to measurement at the health plan level, for example hospital quality and safety
- Comprehensive measures of health care and population health improvement are beyond committee's scope
- Continued partnership with experts – Public Health, Behavioral Health, among others—is required to identify relevant measures that can be tracked at a health plan level
- Specific expanded role for committee would require legislative change

Challenges – Health Care or Health

Health care services influence a small portion of the overall health of a population.

To achieve better health, measures must also address work outside of health care and other factors that impact health – social determinants, behaviors, and environment.

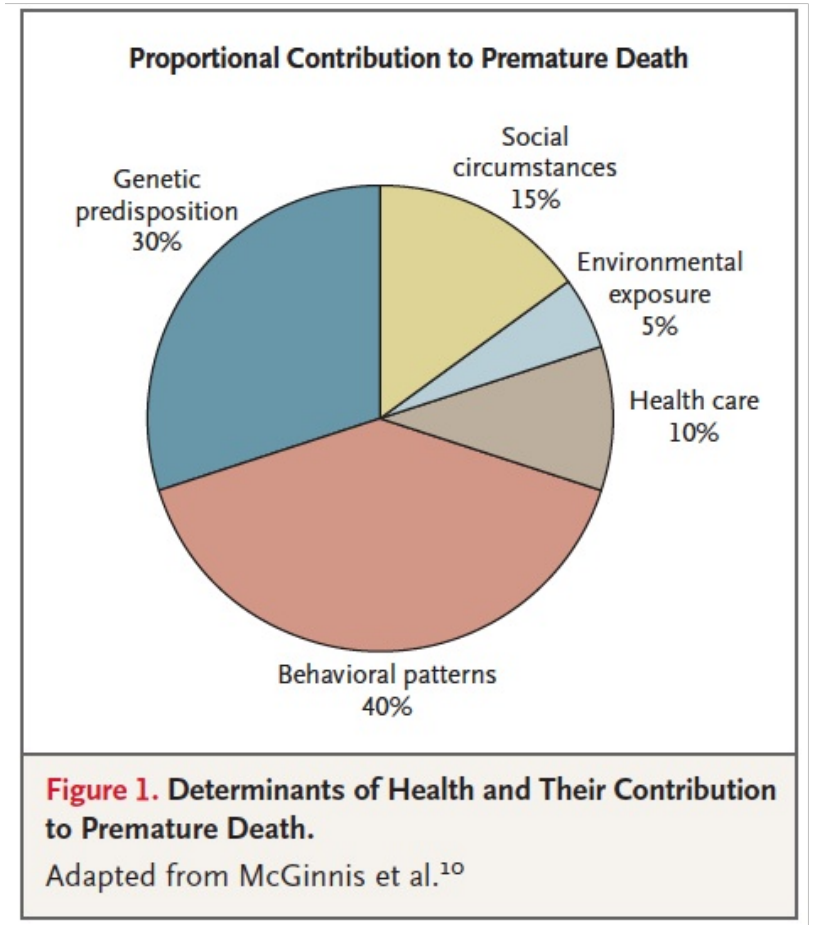
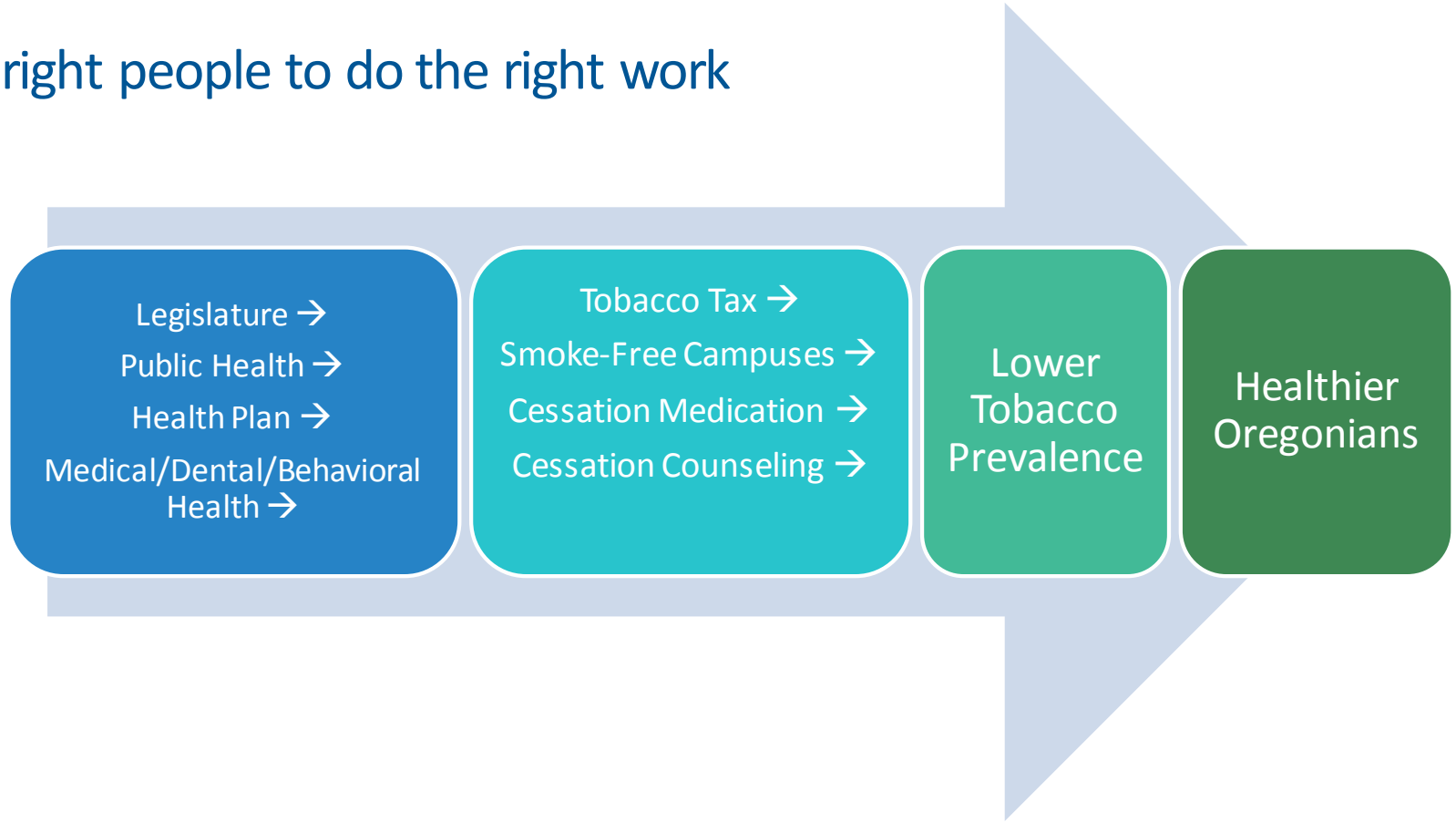


Figure 1. Determinants of Health and Their Contribution to Premature Death.

Adapted from McGinnis et al.[10]

Challenges – Health Care or Health

Ask the right people to do the right work



Challenges – Disparities

No model for a single, universal "disparity measure"

- Strategy A – Improve care for conditions that disproportionately impact populations experiencing disparities
  - Pregnancy outcomes
  - Smoking cessation
- Strategy B – Change and monitor care that is creating disparities
  - Quality or experience of care – cultural and linguistic appropriateness
  - Access to care
  - Metrics that show disparity when analyzed by race/ethnicity, language, and disability status
- Equity Measures Subcommittee will evaluate approaches and make recommendations

Request for Guidance

What gaps in the measures menu for health plans should HPQMC prioritize?

Is there a role for the committee with regard to broader statewide health improvement measures, beyond those aimed at health plans?

Are refinements to the legislative charge for the committee needed?

- No committee seat that specifically holds oral health or dental expertise
- Multiple metrics-development committees in the state. How is their work coordinated?

Contact

Margaret Smith-Isa, MPP

Program Coordinator, PEBB and Staff to Health Plan Quality Metrics Committee

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(503) 378-3958

The Health Plan Quality Metrics Committee meets the second Thursday of each month. Meeting agendas, materials, minutes and recordings can be found on the committee website:

http://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Quality-Metrics-Committee.aspx

Appendix

Impact of Aligned Measures Menu

Quality measures adopted by the HPQMC will impact care delivered to 1.4 million Oregonians

Coordinated Care Organizations	Almost 1.0 million
Public Employees Benefit Board (PEBB)	137,000
Oregon Educators Benefit Board (OEBB)	150,000
Oregon Health Insurance Marketplace (Exchange plans)	131,000

Nearly $180 million are allocated for CCO quality measure inventive payments. This amount will increase as other state programs, such as PEBB and OEBB, begin to incorporate greater dollars at risk tied to quality measure performance in their contracts

Health Plan Quality Metrics Committee Membership

SB 440 defines fifteen committee seats, with committee members appointed by the Governor:

- Oregon Health Authority (OHA, 1 seat)
- Oregon Educators Benefit Board (OEBB, 1 seat)
- Public Employees' Benefit Board (PEBB, 1 seat)
- Department of Consumer and Business Services (DCBS, 1 seat)
- Health care providers (2 seats)
- Hospitals (1 seat)
- Insurers, large employers, or multiple employer welfare arrangements (1 seat)
- Health care consumers (2 seats)
- Coordinated care organizations (2 seats)
- Health care research expert (1 seat)
- Health care quality measurement expert (1 seat)
- Mental health and addiction services expert (1 seat)

HPQMC Vision & Mission

The committee created and adopted the following to guide their work.

Vision

Aligned measurement to promote optimum health and wellbeing for all Oregonians.

Mission

Improving physical, behavioral and dental health for individuals and communities through meaningful and timely quality measures to guide health care purchasing and value.

HPQMC Measure Selection Criteria

To guide measure selection the committee articulated a set of criteria to use as they chose measures for the aligned measures menu from a much larger pool of candidate measures the committee reviewed.

These criteria included guidance provided in SB 440 as well as additional principles the committee articulated and served as a framework during review of individual measures and when assessing the measures menu as a whole.

The committee's measure selection criteria is provided on the following two pages.

HPQMC Measure Selection Criteria

Criteria Applied to Individual Measures

- Utilize existing state and national health outcome and quality measures, including measures adopted by the Centers for Medicare and Medicaid Services
  - that have been adopted or endorsed by other state or national organizations, and
  - have a relevant state or national benchmark *(SB440)*
- Given the context in which each measure is applied, are not prone to random variations based on the size of the denominator *(SB440)* [statistically sound across the population size for which its use is recommended]
- Utilize existing data systems, to the extent practicable, for reporting the measures to minimize redundant reporting and undue burden on the state, health benefit plans and health care providers (*SB440*)
- Present an opportunity for performance improvement (*HPQMC*)
- Can be meaningfully adopted for a minimum of three years (*SB440*)

HPQMC Measure Selection Criteria

Criteria Applied to Individual Measures (continued)

- Use a common format in the collection of the data and facilitate the public reporting of the data (*SB440*)
- Can be reported in a timely manner and without significant delay so that the most current and actionable data is available (*SB440*)
- Promote increased value to providers, patients, and purchasers; for example, measures that align with clinical recommendation and, where possible, are based on an existing body of evidence (*HPQMC*)

Criteria Applied to the Measures Menu as a Whole

- Representative of the array of services that effect health (*HPQMC*)
- Representative of the diversity of patients served by the program (*HPQMC*)
- Collectively parsimonious (menu is limited in number of measures) (*HPQMC*)
- Includes measures with transformative potential (*HPQMC*)

Health Plan Quality Metrics Committee
2019 Aligned Measures Menu

Domain	Measure	Steward	Data Source*	Population Characteristics		Sector					
				Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health**	Hospital	Public Health
Prevention/Early Detection - Physical Health Conditions (16 measures)	Childhood Immunization Status (Combo 2)	NCQA	Claims/Clinical Data	Children	All			Y			Y
	Immunizations for Adolescents (Combo 2)	NCQA	Claims/Clinical Data	Adolescent	All			Y			Y
	Well-Child Visits in the First 15 Months of Life (6 or More Visits)	NCQA	Claims/Clinical Data	Children	All			Y			
	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	NCQA	Claims/Clinical Data	Children	All			Y			
	Developmental Screening in the First Three Years of Life	OHSU	Claims	Children	All			Y			
	Adolescent Well-Care Visit	NCQA	Claims/Clinical Data	Adolescent	All			Y			
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	NCQA	Claims/Clinical Data *(eCQM measure)*	Children, Adolescent	All			Y			
	Chlamydia Screening	NCQA	Claims/Clinical Data *(eCQM measure)*	Adolescent	Female			Y			Y
	Colorectal Cancer Screening	NCQA	Claims/Clinical Data *(eCQM measure)*	Adult, Older Adult	All			Y			
	Breast Cancer Screening	NCQA	Claims/Clinical Data *(eCQM measure)*	Adult, Older Adult	Female			Y			
	Cervical Cancer Screening	NCQA	Claims/Clinical Data *(eCQM measure)*	Adult	Female			Y			
	Effective Contraceptive Use Among Women at Risk of Unintended Pregnancy	OHA	Claims	Adolescent, Adult	Female			Y			Y
	Prenatal & Postpartum Care - Timeliness of Prenatal Care	NCQA	Claims/Clinical Data	Adolescent, Adult, Older Adult	Female			Y			Y
	Prenatal & Postpartum Care - Postpartum Care[1]	NCQA	Claims/Clinical Data	Adolescent, Adult, Older Adult	Female			Y			Y
	Cardiovascular Health Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	NCQA	Claims/Clinical Data	Adult	All		Y	Y			
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	Claims/Clinical Data	Adult	All		Y	Y			

Health Plan Quality Metrics Committee
2019 Aligned Measures Menu

Domain	Measure	Steward	Data Source*	Population Characteristics		Sector					
				Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health**	Hospital	Public Health
Prevention/Early Detection - Mental Health Conditions (1 measure)	Screening for Clinical Depression and Follow-Up Plan[2]	CMS	Claims/Clinical Data *(eCQM measure)*	Adolescent, Adult, Older Adult	All			Y			
Prevention/Early Detection - Substance Use Disorder (SUD) Conditions (4 measures)	Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Claims/Clinical Data *(eCQM measure)*	Adult, Older Adult	All			Y			
	Cigarette Smoking Prevalence	OHA	Clinical Data	Adult, Older Adult	All			Y			
	Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)	OHA	Claims	Adolescent, Adult, Older Adult	All			Y			
	Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT) in the ED	OHA	Claims	Adolescent, Adult, Older Adult	All					Y	
Prevention/Early Detection - Oral Health Conditions (3 measures)	Dental Sealants on Permanent Molars for Children	OHA	Claims	Children, Adolescent	All	Y					
	Members Receiving Preventive Dental Services	OHA	Claims	Children, Adolescent, Adult, Older Adult	All	Y					
	Oral Evaluation for Adults with Diabetes	OHA (modified from DQA/ NCQA)	Claims	Adult, Older Adult	Adults	Y					
Prevention/Early Detection - All Conditions (1 measure)	Mental and Physical Health and Oral Health Assessment Within 60 Days for Children in DHS Custody	OHA	Claims/Social Service Data	Children, Adolescent	All	Y	Y	Y			
Chronic Disease and Special Health Needs - Physical Health Conditions (6 measures)	Controlling High Blood Pressure (NQF)	NCQA	Claims/Clinical Data *(eCQM measure)*	Adult, Older Adult	All			Y	Y		
	Statin Therapy for Patients with Cardiovascular Disease	NCQA	Claims	Adult, Older Adult	All			Y	Y		
	Statin Therapy for Patients with Diabetes	NCQA	Claims	Adult, Older Adult	All			Y	Y		
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	Claims/Clinical Data *(eCQM measure)*	Adult, Older Adult	All			Y			
	Comprehensive Diabetes Care: Eye Exam	NCQA	Claims/Clinical Data *(eCQM measure)*	Adult, Older Adult	All			Y	Y		
	Absence of Controller Therapy[3]	PQA	Claims/Clinical Data	Children, Adolescent, Adult	All			Y	Y		

Health Plan Quality Metrics Committee
2019 Aligned Measures Menu

Domain	Measure	Steward	Data Source*	Population Characteristics		Sector					
				Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health**	Hospital	Public Health
Chronic Disease and Special Health Needs - Mental Health Conditions (4 measures)	Antidepressant Medication Management	NCQA	Claims/Clinical Data *(eCQM measure)*	Adult, Older Adult	All		Y	Y			
	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	NCQA	Clinical Data	Adolescent, Adult, Older Adult	All		Y	Y			
	Follow-Up After Hospitalization for Mental Illness	NCQA	Claims	Children, Adolescent, Adult, Older Adult	All		Y			Y	
	Follow-up After ED Visit for Mental Illness	NCQA	Claims	Children, Adolescent, Adult, Older Adult	All		Y	Y		Y	
Chronic Disease and Special Health Needs - Substance Use Disorder (SUD) Conditions (2 measures)	Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence	NCQA	Claims	Adolescent, Adult, Older Adult	All		Y	Y		Y	
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	NCQA	Claims	Adolescent, Adult, Older Adult	All		Y	Y		Y	
Chronic Disease and Special Health Needs - All Conditions* (2 measures)**	Family Experiences with Coordination of Care (FECC)	Seattle Children's Hospital	Survey	Children, Adolescent	All			Y	Y		
	Pediatric Integrated Care Survey (PICS)	Boston Children's Hospital	Survey	Children, Adolescent	All			Y	Y		
Acute, Episodic and Procedural Care *(Includes Maternity and Hospital)* (5 measures)	Cesarean Rate for Nulliparous Singleton Vertex (PC-02)	TJC	Claims/Clinical Data	Adolescent, Adult, Older Adult	Female			Y		Y	
	Ambulatory Care (AMB-ED)	NCQA	Claims	Children, Adolescent, Adult, Older Adult	All			Y		Y	
	Standardized Healthcare-Associated Infection Ratio	NCQA	Clinical Data	Children, Adolescent, Adult, Older Adult	All					Y	
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	NCQA	Claims/Clinical Data	Adult, Older Adult	All			Y			
	Disparity Measure: Emergency Department Utilization among Members with Mental Illness	Homegrown CCO	Claims	Adult, Older Adult	All		Y	Y		Y	
System Integration and Transformation (2 measures)	Plan All-Cause Readmission	NCQA	Claims	Adult, Older Adult	All					Y	
	Patient-Centered Primary Care Home (PCPCH) Enrollment	OHA	Plan Reporting	Children, Adolescent, Adult, Older Adult	All			Y			
Patient Access and Experience (3 measures)	CAHPS® 5.0H	NCQA	Survey	Children, Adolescent, Adult, Older Adult	All			Y	Y		
	Dental CAHPS	AHRQ	Survey	Children, Adolescent, Adult, Older Adult	All	Y					
	HCAHPS	CMS	Survey	Children, Adolescent, Adult, Older Adult	All					Y	

Health Plan Quality Metrics Committee
2019 Aligned Measures Menu

Domain	Measure	Steward	Data Source*	Population Characteristics		Sector					
				Patient Population	Sex	Dental Health	Behavioral Health	Primary Care	Specialty Physical Health**	Hospital	Public Health
Cost/Efficiency (2 measures)	Total Cost of Care Population-based PMPM Index	HealthPartners	Claims	Children, Adolescent, Adult, Older Adult	All	Y	Y	Y	Y	Y	
	Total Resource Use Population-based PMPM Index	HealthPartners	Claims	Children, Adolescent, Adult, Older Adult	All	Y	Y	Y	Y	Y	

Notes

*Clinical data includes electronic health records, registry data, and paper medical records. Claims/clinical data includes measures that require claims and clinical data, and measures that require claims or claims and clinical data. eCQM measures are indicated using italic font.

**Marc Overbeck shared that OHA counts OB/GYNs as primary care providers when running workforce calculations. Sara Kleinschmit shared that OHA classifies OB/GYNs as a primary care provider if the endorsed measure does as well. For the purposes of this matrix, we have classified OB/GYNs as primary care providers.

***The HPQMC also endorsed the Children with Complex Conditions Supplemental Item Set, found within the CAHPS 5.0H survey under the "Patient Access and Experience" domain.

[1] Will be replaced with "Maternity Care: Post-Partum Follow-Up and Care Coordination" in 2021.

[2] Will be replaced with "Depression Screening and Follow-Up for Adolescent and Adults" in 2021.

[3] Will be replaced with "Optimal Asthma Control" in 2021.

Measure Steward Abbreviations

AHRQ: Agency for Healthcare Research and Quality
AMA-PCPI: American Medical Association-convened Physician Consortium for Performance Improvement
CMS: Centers for Medicare & Medicaid Services
DQA: Dental Quality Alliance
NCQA: National Committee for Quality Assurance
OHA: Oregon Health Authority
OHSU: Oregon Health & Science University
PQA: Pharmacy Quality Alliance
TJC: The Joint Commission

Health Plan Quality Metrics Committee Roster
May 2018

Name	Title	Organizational Affiliation	Location by County
Maggie Bennington-Davis	Chief Medical Officer	Health Share of Oregon	Multnomah
Description/Background: Maggie currently serves as the Chief Medical Officer with Health Share of Oregon. Maggie has served on the CCO Metrics and Scoring Committee as both a member and the Chair of the committee. Maggie fills one of two committee seats representing coordinated care organizations.			
Kristen Dillon (Chair)	Director	PacificSource Columbia Gorge CCO	Hood River
Description/Background: Kristen currently serves as the Director of the Columbia Gorge CCO, employed by PacificSource Community Solutions since 2015. Prior to that, Kristen was an owner of an independent primary care practice in Hood River where she worked as a family physician for 15 years. Kristen continues to work in a limited capacity at the frontier clinic in Sherman County. Kristen fills one of two committee seats representing health care providers and currently serves as the committee Chair.			
Benjamin LeBlanc	Chief Medical Officer	Providence Medical Group	Multnomah
Description/Background**:** Benjamin currently serves as physician and Chief Medical Office for Providence Medical Group in Oregon. Benjamin has been with Providence for 18 years in various roles, including faculty for residency training, electronic health record and software design consultant for quality improvement, and physician manager responsible for achieving quality outcomes. Additionally, Benjamin works with government and private payers to design and implement pay for performance programs and develop reimbursement strategies focused on improved outcomes. Benjamin fills one of two committee seats representing health care providers.			
Lynnea Lindsey	Director of Behavioral Health Services	Legacy Health	Multnomah
Description/Background: Dr. Lindsey currently serves as the Director of Behavioral Health Services for Legacy Health. Lynnea is a licensed psychologist with two decades of experience working in Oregon healthcare at both a clinical and operational/administrative level. Lynnea has worked as a consultant to several CCOs and health plans as well as provider organizations in Oregon to develop programs to clinically and financially support as well as evaluate the work of integrated physical and behavioral health services. Lynnea has worked with a variety of state committees as well. Lynnea is currently the chair of the Integrated Behavioral Health Alliance of Oregon (IBHAO) and board member of CCO Oregon. Lynnea fills the committee seat representing individuals with expertise in mental health and addiction services.			

Health Plan Quality Metrics Committee Roster
May 2018

Name	Title	Organizational Affiliation	Location by County
Jeff Luck	Associate Professor	Oregon State University	Benton
Description/Background: Jeff Luck, MBA, PhD is Associate Professor of Health Management and Policy at Oregon State University's College of Public Health and Human Sciences. He is Chair of the Oregon Public Health Advisory Board and a past member of the OHA Metrics and Scoring Committee. Jeff fills the committee seat representing individuals with expertise in health care research.			
Melinda Muller	Clinical Vice President for Care Transformation	Legacy Health	Multnomah
Description/Background: Melinda currently serves as the Clinical Vice President for Care Transformation at Legacy Health. Melinda has been a primary care physician in Oregon for 20 years. Melinda has 10 years of experience measuring and demonstrating improvement with HEDIS, STARS and other internal measures within primary care. Melinda led the transformation of the primary care clinics to become medical homes, certified by Oregon as well as NCQA. Melinda fills the committee seat representing hospitals.			
Raj Mummadi	Chief of Quality, Ambulatory Care & Population Health	Kaiser Permanente Northwest Region	Multnomah
Description/Background: Raj currently serves as the Chief of Quality for Ambulatory Care and Population Health at Kaiser Permanente Northwest Region. Raj is also a clinical gastroenterologist in practice for over 10 years. Prior to joining Kaiser Permanente, Raj was a teaching faculty at OHSU. Raj has graduate level training in outcomes research, epidemiology and biostatistics as part of his graduate degree in clinical investigation. Raj fills the committee seat representing insurers, large employers or multiple employer welfare arrangements.			
Ana Quiñones	Assistant Professor	OHSU-PSU School of Public Health	Multnomah
Description/Background: Ana currently serves as an Associate Professor in the Department of Family Medicine at OHSU with a secondary appointment in the OHSU-PSU School of Public Health. Ana is also an affiliate investigator for the Portland Veterans Affairs Health Care System. Ana fills one of two committee seats representing health care consumers.			
Bhavesh Rajani	Medical Director	Yamhill CCO	Yamhill
Description/Background: Bhavesh currently serves as the Medical Director for Yamhill CCO. Previously, Bhavesh was in a leadership role at Providence Medical Group. With a background in family practice, Bhavesh has a strong knowledge basis on the impact of metrics determination on primary care related work. Bhavesh fills one of two committee seats representing coordinated care organizations.			

Health Plan Quality Metrics Committee Roster
May 2018

Name	Title	Organizational Affiliation	Location by County
Colleen Reuland	Director	Oregon Pediatric Improvement Partnership (OPIP)	Multnomah
Description/Background: Colleen currently serves as the Director of OPIP as well as an instructor in the pediatrics department at OHSU. Colleen has spent her 19 year career focused on applied quality measurement and improvement activities. Colleen has lead the development and implementation of a number of standardized metrics that have been implemented at the state, health plan, provider and community-level and have been endorsed by the National Quality Form Forum and National Quality Measures Clearing house. Colleen brings experience having served on and observed several state committees in the past including the Primary Care Payment Reform Collaborative and the Measuring Success Work Group. Colleen fills the committee seat representing individuals with expertise in health care quality measures.			
Vacant	**One seat representing health care consumers**		
Chiqui Flowers	Administrator	DCBS Oregon Health Insurance Marketplace	Marion
Description/Background: Chiqui currently serves as the Administrator of the Oregon Health Insurance Marketplace. Chiqui joined Oregon's Marketplace in 2013 and has been a part of implementing every open enrollment effort since the first year. Chiqui was also instrumental in designing, implementing and operating the Oregon program that facilitates Medicaid-equivalent coverage for low-income COFA islanders. Chiqui fills the committee seat representing the Department of Consumer and Business Services.			
Jon Collins	OHA Representative (Interim)	Oregon Health Authority	Marion
Description/Background**:** Jon Collins currently serves as the Director of Health Analytics for the Oregon Health Authority**.** Jon has been a part of OHA in various roles of leadership associated with the government healthcare field for the past 17 years. Prior to joining OHA, Jon served as the quality improvement manager for a rural managed care company contracted for Medicaid behavioral health services in Oregon. Jon is an accomplished researcher and maintains an adjunct appointment with OHSU's psychiatry department. Jon fills the committee seat representing the Oregon Health Authority.			
Shaun Parkman (Vice-Chair)	Board Chair	PEBB	Multnomah
Description/Background: Shaun serves as an evaluation specialist in the Oregon Public Health Division and is a member of the Service Employees International Union (SEIU), Local 503. Shaun also currently serves as Vice-Chair of the Public Employees' Benefit Board (PEBB) and have served on the Board since 2015. Shaun is a Southern/Midwest transplant and have loved living in Portland since 2010. Shaun stays active by hiking with his wife and daughter. Shaun fills the committee seat representing the Public Employees' Benefit Board and currently serves as the committee Vice-Chair.			

Health Plan Quality Metrics Committee Roster
May 2018

Name	Title	Organizational Affiliation	Location by County
Tom Syltebo	Board Member	OEBB	Multnomah
Description/Background: Tom is a retired physician who has worked in Oregon healthcare as a primary care physician, hospital chief of staff, operations medical director, and medical group liaison. He represented Kaiser Permanente before the OEBB Board for five years as KP Northwest Region's Clinical Quality Representative, and continues to participate with Oregon Health Care Quality Corporation/Healthinsight Oregon, an organization dedicated to providing comprehensive, actionable, statewide medical information to all stakeholders. Tom fills the committee seat representing the Oregon Educators Benefit Board.			

Committee Demographic Information

14 Total Members (1 vacant seat)

- Gender: 7 female; 7 male
- Race: Asian/Pacific Islander (2); Latina/Hispanic (1); White (11)
- Ethnicity: Hispanic (1); Non-Hispanic (13)
- Geography: Multnomah County (9); Hood River (1); Benton (1); Yamhill (1); Marion (2)
- Disability: Disability (0)